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ABSTRACT

Intended for child welfare caseworkers and others working with children and families in crisis, this guide presents principles and techniques of crisis intervention with child abuse or neglect cases. After an overview of the manual, the first section considers a definition of crisis, the elements and phases of crises, and the psychological effects of crises. In the next section, the goals and steps of crisis intervention are introduced using a nine-step model and discussion of crisis teams. The third section provides suggestions for total family involvement in the assessment of the precipitating circumstances and of future risk to the children. The following two sections consider specific treatment approaches (such as the community systems, cognitive-behavioral, or family treatment approaches) and techniques (such as the use of humor and setting limits) as well as special family situations (such as marital conflict, substance abuse, and poverty). The next section offers suggestions for termination and follow-up. The last two sections address the professional supports needed by the crisis intervention worker and five family-centered crisis response models. A summary, glossary of terms, footnote references, and a selected bibliography complete the manual. (Contains 125 references.) (DB)

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National Center on Child Abuse and Neglect

Crisis Intervention in Child Abuse and Neglect

The User Manual Series

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

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Crisis Intervention in Child Abuse and Neglect

Charles E. Gentry

1994

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

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PREFACE

The Child Abuse Prevention and Treatment Act was signed into law in 1974. Since that time, the Federal Government has served as a catalyst to mobilize society's social service, mental health, medical, educational, legal, and law enforcement resources to address the challenges in the prevention and treatment of child abuse and neglect. In 1977, in one of its early efforts to achieve this goal, the National Center on Child Abuse and Neglect (NCCAN) developed 21 manuals (the User Manual Series) to provide guidance to professionals involved in the child protection system and to enhance community collaboration and the quality of services provided to children and families. The manuals described each professional's roles and responsibilities in the prevention, identification, and treatment of child maltreatment. Other manuals in the series addressed special topics, for example, adolescent abuse and neglect.

Our understanding of the complex problems of child abuse and neglect has increased dramatically since the user manuals were developed. This increased knowledge has improved our ability to intervene effectively in the lives of troubled families. Likewise, we have a better grasp of what we can do to prevent child abuse and neglect from occurring. Further, our knowledge of the unique roles key professionals can play in child protection has been more clearly defined, and a great deal has been learned about how to enhance coordination and collaboration of community agencies and professionals. Finally, today we are facing new and more serious problems in families that maltreat their children. For example, there are significantly more families known to Child Protective Services (CPS) that are experiencing substance abuse problems.

Because our knowledge base has increased significantly and the state of the art of practice has improved considerably, NCCAN has updated the User Manual Series by revising many of the existing manuals and creating new manuals that address current innovations, concerns, and issues in the prevention and treatment of child maltreatment.

As a supplement to the manual *Child Protective Services: A Guide for Caseworkers*, this manual, *Crisis Intervention in Child Abuse and Neglect*, is intended for caseworkers who want to improve their assistance to children and families in crisis. Other professionals in the field of child protection, such as law enforcement officers, judges, educators, health care providers, and mental health counselors, may also find the information on crisis intervention helpful.

ACKNOWLEDGMENTS

Charles E. Gentry, L.C.S.W., is executive director of Child and Family Services, a multiservice agency in middle east Tennessee. He has 32 years of experience in juvenile court, child welfare, psychiatric hospital, outpatient psychiatric, family service, general hospital, and private practice settings. He has specialized in assessment and treatment of violence in families, as well as in writing and providing training across the United States. He is an adjunct professor at Carson Newman College.

Recognition is given to Lori Hill, Darnell Bean, and other Child and Family Services' staff for the typing and preparation of this manual.

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OVERVIEW OF THE MANUAL

In the past, emergency room, law enforcement, and disaster relief teams developed distinct protocols for responding to family crises. The 1970's and 1980's brought about coordinated intervention among community agencies and organizations responsible for responding to crises in cases of child abuse and neglect. Growing concern about family violence stimulated the study and development of improved crisis-intervention approaches.

There has been a growing misconception regarding the definition of crisis intervention. In Child Protective Services' (CPS) practice, the terms "crisis intervention" and "emergency services" have sometimes been used interchangeably. This manual attempts to differentiate between emergency services and crisis intervention, further defining the territory and practice of crisis intervention with CPS cases.

Crisis intervention and assessment are the first steps in strengthening clients' problem-solving skills. Instead of studying the client's or family's background, the crisis workers assess and focus on the unresolved problems that led to the crisis. Client and crisis worker energies are fully focused on the precipitating events and the problem-solving process. A solution-focused paradigm, which addresses the clients' concerns, can generate cooperation and quicker solutions to the crisis.

Problem-solving or task-centered approaches can prevent unclear, unfocused crisis intervention. By helping clients think about what has worked for them in the past and what might be more effective now, planning and action steps are put in place for resolving the family's problems.

Crisis intervention emphasizes that clients have the strengths to resolve crises. Crisis workers help clients discover and use their potential. The crisis workers' positive attitude about the clients' abilities has a powerful suggestive impact on clients.

Therefore, crises present a unique opportunity for change in the lives of the parents and children involved. During a period of intense crisis, when usual methods of coping fail, families become more open to new problem-solving approaches. Moreover, during this period of imbalance, they are willing to consider that change for the better is possible.

This manual, while addressing principles and techniques of crisis intervention with child abuse or neglect cases, recognizes the interrelatedness of all forms of intrafamilial and societal violence. Any situation involving suspected child abuse or neglect is a crisis. "Crisis intervention" refers to the approach or techniques used by those individuals or teams who respond to the crisis. Crisis intervention is a planned response that requires specialized roles, training, and supervision.

This section has presented a brief overview of crisis. A definition of crisis, the elements and phases of crises, client feelings, and the psychological effects of crises are the focus of the next section, "Understanding Crisis." "Crisis Intervention Goals and Steps" introduces the goals and steps of crisis intervention with a nine-step model and discussion of crisis teams. "Crisis Intervention Assessment" provides suggestions for total family involvement in the assessment of the precipitating circumstances and of future risk to the children.

"Crisis Intervention Treatment Approaches and Techniques" and "Understanding Special Family Situations" consider specific treatment approaches and techniques and special family situations respectively, while "Termination and Follow-up Services" offers suggestions for termination and follow-up.

"Crisis Intervention Worker" and "Family-Centered Crisis Response Models" address the professional supports needed by the crisis intervention worker and five family-centered crisis response models, followed by a summary, a glossary of terms, footnote references, and a selected bibliography.

UNDERSTANDING CRISIS

INTRODUCTION

Family crises are not unusual events in the field of child protection. A child's disclosure of sexual molestation, the birth of a drug-addicted infant, the discovery of a teenager's dependence on drugs, a parent's arrest for violent behavior, the threat of a family's eviction from public housing, or a parent overwhelmed with the needs of a child illustrate just some of the crises experienced by families. Although the state of crisis is short lived, generally lasting 4 to 6 weeks, it is a period of heightened family vulnerability and imbalance that requires a carefully planned response.

This section provides an overview of crisis, its definition, elements, and phases. In addition, the feelings and psychological effects typically experienced by family members in crisis are presented to increase awareness of the ramifications of crisis.

DEFINITION OF CRISIS

"A *crisis*," as defined in *Crisis Intervention Book 2: The Practitioner's Sourcebook for Brief Therapy*, "is an upset in a steady state, a critical turning point leading to better or worse, a disruption or breakdown in a person's or family's normal or usual pattern of functioning. The upset, or disequilibrium, is usually acute in the sense that it is of recent origin."[1] A crisis constitutes circumstances or situations which cannot be resolved by one's customary problem-solving resources.

A crisis is different from a problem or an emergency. While a *problem* may create stress and be difficult to solve, the family or individual is capable of finding a solution. Consequently, a problem that can be resolved by an individual or a family is not a crisis.

An *emergency* is a sudden, pressing necessity, such as when a life is in danger because of an accident, a suicide attempt, or family violence. It requires immediate attention by law enforcement, CPS, or other professionals trained to respond to life-threatening events. If a situation can wait 24 to 72 hours for a response, without placing an individual or a family in jeopardy, it is a crisis and not an emergency.

ELEMENTS OF CRISES

The three basic elements of a crisis—a stressful situation, difficulty in coping, and the timing of intervention—interact and make each crisis unique.

Stress-Producing Situations

Everyone experiences times then they feel upset, disappointed, or exhausted. When such feelings are combined with certain life events or situations, they often lead to mounting tension and stress. There are five types of situations or events that may produce stress and, in turn, contribute to a state of crisis:

- **Family Situations**—a child abuse investigation, spouse abuse, an unplanned pregnancy, a parent's desertion, a chronically ill family member, and lack of social supports are examples of family situations that can create stress and crises.

- **Economic Situations**—sudden or chronic financial strain is responsible for many family crises, such as loss of employment, a theft of household cash or belongings, high medical expenses, missed child support payments, repossession of a car, utilities cut off from service, money "lost" to gambling or drug addiction, and poverty.

- **Community Situations**—neighborhood violence, inadequate housing, a lack of community resources, and inadequate educational programs illustrate some ways the community may contribute to family crises.

- **Significant Life Events**—events that most view as happy, such as a marriage, the birth of a child, a job promotion, or retirement, can trigger a crisis in a family; a child enrolling in school, the behaviors of an adolescent, a grown child leaving the home, the onset of menopause, or the death of a loved one can also be very stressful life events.

- **Natural Elements**—crises are created by disasters such as floods, hurricanes, fires, and earthquakes, or even extended periods of high heat and humidity, or gloomy or excessively cold weather.

Difficulties in Coping

An individual's or a family's ability to deal with a crisis situation is influenced by their physical and behavioral characteristics and their attitudes and beliefs. Even families with generally happy lives and networks of support can become overwhelmed by stressful events. For example, poor physical health, a low level of personal energy, an overly sensitive temperament, and mistrust of community service providers set the stage for difficulty in coping with a crisis.

Families that have problem-solved well in the past will be quick to benefit from crisis intervention. With encouragement, support, and a focus on the problem-solving process, they will soon regain their coping skills and stabilize. For example, one case referred to CPS involved the neglect of a young child. The child's mother was depressed about her ex-husband's threats of a custody fight. Feeling hopeless about a legal battle, the mother began to blame and neglect her child. As a result of crisis intervention, the mother quickly regained hope, secured legal counsel, and realized that she could "stand up to the threats." Within a period of 3 weeks, the mother was appropriately parenting her child again and finding joy in life.

Parents with Chronic Coping Problems

Many families in the CPS system do not have experience in solving problems well. Rather, they seem to have continual difficulties in several areas of their life. Indicators distinguishing the two types of families—those in acute crisis and those in chronic crisis—are presented in exhibit I.

It is not the task of crisis workers (also known as crisis interveners) to "cure" every dysfunction within "chronic crisis" families. Instead, it is more critical to focus on one to four specific stresses which created the immediate crisis. If a family can learn to focus on and find solutions to a limited number of crisis-producing problems, then the family members will have learned how to problem solve, and they will feel more in control of their destiny. As one client said, "Until you taught me to focus on one thing at a time, I felt like I was a bad person because I couldn't fix everything. Now I see that I was just running from one problem to another and not fixing anything."

EXHIBIT I *
INDICATORS DISTINGUISHING FAMILIES IN ACUTE CRISIS FROM THOSE IN CHRONIC CRISIS

Acute Crisis— Parents Fundamentally Able To Cope but Temporarily Overwhelmed	**Chronic Crisis— Parents with Continual and Serious Child-Rearing Difficulties**
• Major crisis or series of crises • History of adequate child care • Regular employment • Sufficient income and skills • Emotional support from friends and relatives • Average problem-solving abilities • Generally good physical health, minimal use of illegal substances, and essentially no illegal activity • Adequate education and housing that allow for individual space and organization of belongings • Intimacy is non-sexualized • Acceptance of differences of opinion • Family members understand and accept their respective roles • Generally good mental health • Likely to be cooperative with genuinely supportive child protection personnel, welcoming offers of help • Likely to regain ability to solve problems themselves when crisis has passed	• Constantly in stressful situation or crisis • Little parenting knowledge • Limited education/vocational opportunities and skills • Poverty • Extreme social isolation • Little support from relatives or community • Poor problem-solving skills; blame others • Ill health, substance abuse, drug dealing, legal problems, physical handicap • Overcrowded or run down housing, cluttered areas, economically disadvantaged • Prostitution, sex abuse, abuse between adults • Social, racial, or cultural discrimination • Poorly defined role boundaries in the family • Chronic mental illness or character • Distrustful of professional helpers • A new crisis arises, even though there is relief from a previous crisis

* Adapted from *Crisis Intervention: A Manual for Child Protective Workers*, by R. Borgman, M. Edmunds, and R. MacDicken, U.S. Department of Health, Education and Welfare, National Center on Child Abuse and Neglect, 1979, p. 7.

People with chronic coping difficulties tend to be constantly in stressful situations and must cope with several major problems which occur simultaneously, e.g., unemployment, inability to pay bills, problems with the landlord, marital disharmony, and neighborhood complaints about their children or the appearance of the yard.[2] Any new stress, such as the utilities being disconnected, may be "the straw that breaks the back" of these families. Instead of being supportive to each other, family members try to place blame. Arguments or violence between the adults may lead to child abuse or neglect or vice versa. Substance abuse, adolescent gang activity, or a runaway or pregnant teenager may indicate that the family has chronic coping problems.

Once families learn to problem-solve, they have new hope for the future, giving them the energy to address some of the antecedents to the current crisis. Again, crisis workers must focus on restoring stability and teaching families how to solve problems, rather than solving the problems for them. When crisis workers assist families in solving a crisis, the families are also helped to avoid future crises. Many of these families, however, need to be referred to mental health or substance abuse counselors for resolution of past emotional traumas, such as childhood sexual abuse or for treatment of addictions, depression, and other emotional disorders.

Timing of Intervention

As stated previously, crises typically last 4 to 6 weeks during which time problem-solving is critical. A timely, therapeutic response is likely to prevent a severe breakdown in family relationships and restore adequate functioning. It is at this time that the family is most open to intervention. By intervening in a timely manner and by assisting the family in overcoming situational factors which led to the crisis, stabilization is likely to occur within a few weeks.

Initially, the crisis worker may remain with the family for several hours, if needed. As the situation progresses or becomes more intense, the crisis worker's time with the family is adjusted to fit the situation. As termination is approached, fewer hours should be required. Throughout the process, the crisis worker should be available at all times.

THE PHASES OF CRISIS

When individuals or families face certain levels of stress or combinations of stress, crises occur. These crises are likely to have a sequence, or series of phases, as described below. Although presented as seven distinct phases, the phases of crisis may overlap or intertwine.

The following configuration of crisis phases is adapted and expanded from the four interlocking phases found in *Crisis Intervention Book 2: The Practitioner's Sourcebook for Brief Therapy.*[3]

- **Phase I: Precipitating Event**—an unusual, unanticipated, stressful, or traumatic precipitating event occurs, causing an initial rise in anxiety. The individual and family respond with familiar problem-solving mechanisms.

  The precipitating event may be a report of child sexual abuse or an investigation by authorities of drug-related activities in a family. Another example is a parent who loses a job. Feeling hurt and vulnerable, the parent may displace his or her anger by physically harming a child. In turn, there is a new precipitating event, a child abuse investigation with its own potential for creating a family crisis.

- **Phase II: Perception**—the individual or family perceives the event or accusation as meaningful and as a threat to individual or family goals, security, or ties of affection. For instance, a family may perceive a complaint of abuse or neglect as a threat to family integrity and interpersonal security (e.g., when there is the possibility of removing a father who has been accused of sexually abusing his adolescent or the possibility of removing an adolescent who has behaved in a belligerent manner).

- **Phase III: Disorganized Response**—unfamiliar feelings of vulnerability and helplessness escalate as behaviors, skills, or resources used in the past to solve problems fail. The family's anxiety rises, and members seek an immediate and original solution to the psychological stress.

  In turn, the family's response to the stressful crisis becomes increasingly disorganized.

- **Phase IV: Seeking New and Unusual Resources**—in their attempt to decrease tension and resolve the emotional pain, family members begin to involve other people. Since each family member has a different perception of the threat and of who might be able to help, he or she may seek validation for his or her viewpoint both within and outside the family. Neighbors, relatives, and friends will offer both direct assistance (alternative housing, transportation, food, money, etc.), and advice ("call the police," "be more submissive and your husband/father will calm down," "leave the abuser," etc.). The family needs a nonjudgmental, well-trained crisis worker during this phase, rather than conflicting advisors.

  While the family is feeling helpless, crisis intervention can be quite effective because the family is open to help that offers them some protection, security, or support. Compassion, mixed with appropriately firm limits, can give the family a sense of security or protectedness. This requires the crisis worker to listen actively to what the family says it needs to become stable.

- **Phase V: A Series or Chain of Events**—most crises set off a chain of events which can create yet another crisis for the family. For example, a crisis may begin with a parent experiencing a drug-induced personality change, becoming violent in the family, and spending the rent on drugs. If crisis-intervention services are not provided, eviction from housing may ensue, setting off another crisis.

- **Phase VI: Previous Crises Become Linked to Current Crisis**—crises tend to spur memories of past traumatic or crisis events involving loss of control. For instance, a mother who has suppressed her sexual victimization by her father may become acutely aware of it when her intoxicated boyfriend makes sexual advances toward her daughter. Likewise, when a child is physically abused by one parent, the other parent may have flashbacks about beatings in his or her childhood.

- **Phase VII: Mobilization of New Resources, Adaptation**—this phase represents a turning point, when the tension and struggle evolve into mobilization of new resources or ways of adapting. This can occur when a family with a history of substance abuse attends Alcoholics Anonymous and Al-Anon meetings, seeks different housing or job training, or decides to listen when other family members are talking.

  Since there is the possibility that an unresolved crisis may lead to further maladaptive behaviors, such as more vicious fighting or a heavier reliance on substance abuse, it is the job of crisis workers to help families seek and implement acceptable crisis-resolution strategies.

CLIENT FEELINGS DURING CRISIS

Howard and Libbie Parad describe the anxiety-ridden responses of people in crisis as including "...upsets in eating, sleeping, dreaming, lovemaking, feeling, thinking, and doing." They believe that the following nine emotional reactions of people in crisis, as discovered by the Benjamin Rush Center for Problems of Living, can help professionals better understand and work with crises:

- Bewilderment: Experiencing new and unusual feelings.
- Danger: Feelings of tension, fear, and impending doom.
- Confusion: Mind is muddled and not working well.
- Impasse: Feeling stuck; nothing works.
- Desperation: Need to do something, but what?
- Apathy: Why try?
- Helplessness: Need someone to help me.
- Urgency: Need help right now.
- Discomfort: Feeling miserable, restless, unsettled.[4]

PSYCHOLOGICAL EFFECTS OF CRISIS

While differences in coping abilities, stress-producing situations, and timing of intervention make each crisis unique, individuals in crisis experience some common psychological effects that affect assessment and treatment. Forming a working relationship with the parents, when responding to a crisis caused by child maltreatment or when dealing with parents in any other child-rearing crisis situation, requires anticipation of these effects.

Generally, crisis events produce problems in six broad areas as described below. Such problems are temporary, however, and not indicators of mental illness. A crisis is transient, as are the temporary responses of the family members. Anyone can have a crisis. Therefore, being in crisis is not synonymous with being mentally ill.

Disorganized Thinking

People in crisis experience a disorganization in their thinking process. They may overlook or ignore important details and distinctions that occur in their environment and may have trouble relating ideas, events, and actions to each other in logical fashion. They may jump from one idea to another in conversation so that communication is confusing and hard to follow. They may not notice or may have forgotten exactly what happened, or who did what to whom. Important details may be overlooked in interpreting events, such as a client's giving extensive information about a house fire, but failing to tell that her brother had three previous charges of arson. Fears and wishes may be confused with reality, manifesting a general feeling of confusion. Some people in crisis develop one-track minds, repeating the same words, ideas, and behaviors which "worked" in the past, but are inappropriate in the current situation. These people may seem unable to move on to new ideas, actions, or behavior necessary to solve the current crisis.

Preoccupation with Insignificant Activities

In an attempt to combat disorganized thought processes and anxiety, people in crisis tend to become very involved in insignificant or unimportant activities, such as worrying that someone will be overwhelmed with bad air by keeping a window open. At the peak of crisis, then, these individuals may need considerable help in focusing on important activities, such as implementing the steps for productively resolving the crisis.

Expression of Hostility and Emotional Distancing

Some people in crisis are so upset over their loss of control that they become hostile toward anyone who intervenes in the situation. They resent their need for help, feeling both angry and vulnerable. Other crisis-ridden people react with extreme emotional distancing and passivity, seeming not to be emotionally involved in the situation or concerned with its outcome. For crisis workers, the issue is not how to give directives, but to point out the choices for handling the crisis and to reinforce strengths.

Impulsiveness

While some people are immobilized in crisis situations, others are quite impulsive, taking immediate action in response to the crisis without considering the consequences of their action. Their failure to evaluate the appropriateness of their responses may provoke further crises, thus making an already complex situation even more difficult to resolve.

Dependence

Dependence on the crisis worker at a time of crisis is a natural response and may be necessary before an individual can resume independence. In cases of child abuse and neglect, protection of the children may require the crisis worker to do for the parents what most other parents do for themselves. For example, the crisis worker may need to call a creditor or the utility company or help parents in structuring the basics of child care.

During a crisis, perceptions of the crisis worker's power or authority can have a stabilizing impact on a family. A family in crisis is likely to welcome an objective, skillful, and kind authority who knows how to "get things done." Offers of help from a concerned, competent crisis worker seem the answer to all the family's difficulties.

After a brief period of dependency, most families are able to resume independent functioning. For some families in crisis, however, dependency may linger. The need to have someone else in charge makes these families particularly susceptible to influence from others, rendering them more vulnerable. In their need to find solutions, they may not be able to discriminate between what is beneficial for them and what could be harmful or, in the absence of a competent crisis worker, to whom they should listen.[5]

Threat to Identity

Identity is both an inner condition and an interactional process. When an event, such as a child abuse report, threatens one's self-concept and family relationships, a crisis occurs. Because usual coping methods fail, one's sense of personal identity is impaired, causing disequilibrium.[6] One's previous feelings of competency and worth may seem totally lost.

To counter a lowered self-perception, a parent in crisis may assume a facade of adequacy or arrogance, claiming that no help is needed. Or, the parent may withdraw from offers of help. In either case, it is important to remember that the parent in crisis is probably very frightened, rather than "resistant" or "unmotivated." The crisis worker has the opportunity to establish rapport by recognizing strengths that help to restore a sense of goodness or individual worth. The crisis worker cannot accept abuse of a child, but does acknowledge the parent's and family's strengths.

SUMMARY

During a state of crisis, individuals and families are usually quite receptive to intervention. The anxiety produced by the crisis, coupled with the realization that past coping and problem-solving strategies are not working, spurs motivation to learn new strategies. If help is not available during this critical period of openness to change, the individual and family may become totally immobilized or resort to destructive or maladaptive behaviors. Therefore, it is critical that CPS caseworkers quickly identify crisis situations.

In identifying a crisis situation, it is important to consider its contributing elements: What specific situations or events are creating the most stress for the individual and the family? What difficulties in coping are evident? At what point in time is intervention occurring?

The phase of the crisis must also be considered. Feelings and behaviors that on the surface appear bizarre, may be, in fact, characteristic of the crisis phase. Correct interpretation of the crisis phase is essential to appropriate intervention. For instance, clients whose crises are chronic or multiple may require referrals to follow-up clinicians who can further address underlying issues.

Finally, it is important to be aware of the feelings people typically experience during a state of crisis. A crisis can have a devastating impact on one's senses and psychological functioning. However, that impact is often short lived when interpreted and dealt with correctly.

CRISIS INTERVENTION GOALS AND STEPS

INTRODUCTION

Crisis intervention begins at the first moment of contact with clients.[7] Consequently, community coordination in its planning and implementation results in tremendous benefits to families. In a matter of weeks, families may achieve progress that is the equivalent of 1 or 2 years of traditional case management and treatment. In fact, families are most ready to change their nonproductive approaches to problem-solving during a time of crisis.

Crisis intervention focuses on one to four goals that are chosen by the family. Intervention is time limited, usually between 4 to 12 weeks, family-centered, and occurs in the family's home much of the time. Concrete services, along with counseling and referral to community resources, are provided by one or more crisis workers.

Crisis workers representing some combination of CPS, family preservation, and other crisis workers, are available 24 hours per day, 7 days per week. Using eclectic, solution-focused approaches, they concentrate on family strengths, rather than weaknesses, believing that families have the knowledge and skills to solve their own problems. The major focus is on the here and now, but linkages to the past may be explored in order to break a repetitive cycle of inappropriate problem-solving or self-destructive behaviors. All crisis intervention programs emphasize safety for the children. Concern for the safety of other family members and crisis workers is rapidly evolving as a part of good practice.

In addition to the scope and goals of crisis intervention, this chapter considers the following: a nine-stage model of crisis intervention, crisis-intervention teams, crisis as an opportunity to initiate change, and crisis intervention as a planned response.

THE SCOPE AND GOALS OF CRISIS INTERVENTION

A focus on limited goals and objectives is essential for crisis intervention. This is particularly true with families in which disorganization and lack of finality perpetuate chaos.

Six Goals of Crisis Treatment

As proposed by Lydia Rapoport in *Crisis Intervention as a Mode of Brief Treatment*, crisis intervention is guided by six primary goals, all aimed at stabilizing and strengthening family functioning. These goals are to:

- relieve the acute symptoms of family stress;
- restore the family and family members to optimal pre-crisis levels of functioning;
- identify and understand the relevant precipitating event(s);
- identify remedial measures that the family can take or that community resources can provide to remedy the crisis situation;

- establish a connection between the family's current stressful situation and past experiences; and
- initiate the family's development of new ways of perceiving, thinking, and feeling, and adaptive coping responses for future use.[8]

Since crisis intervention is time limited, an attempt to achieve too many goals leads to disappointment and feelings of failure. While clients should be encouraged to stretch their resources or abilities, they cannot be expected to go in too many directions or too far beyond their basic abilities. It is better to help clients view life as a "practice field" where they practice repetitively to accomplish a goal, or as a "house" where they put one piece of progress (building block) on top of the other until the goal is achieved.

A NINE-STEP CRISIS INTERVENTION MODEL

The following model incorporates steps from a seven-stage model for crisis intervention.[9] This nine-stage model is slightly more comprehensive.[10]

Step 1: Rapidly Establish a Constructive Relationship

In the first step, the emphasis is on crisis worker sincerity, respect, and sensitivity to clients' feelings and circumstances. Crisis workers must listen and observe for long periods of time. As Puyear states in *Helping People in Crisis*, "Active listening entails listening for the latent, underlying, coded message and then checking to see if you've gotten it correctly."[11]

Active listening gives clients a chance to develop their own strengths. By assuming that clients are motivated, they are supported in thinking through their solutions, which enhances their self-respect. "The worker," Puyear continues, "must assure that the client feels that something useful has been accomplished in the first session and that there is promise of something useful being accomplished in the next."[12] Rapport is enhanced by showing respect and unconditional positive regard for clients. Crisis workers need to start with the assumption that people are basically good.[13]

Step 2: Elicit and Encourage Expression of Painful Feelings and Emotions

Anger, frustration, and feelings related to the current crisis are the focus of intervention rather than issues in the past. Linkages to past crises and repetitive, ineffective responses to problems can be explored at a later time.

Step 3: Discuss the Precipitating Event

After rapport is established, the focus turns to the family perceptions of the situation, the chain of events leading up to the crisis, and the problem that set off the chain of events. Discussions examine when and how the crisis occurred, the contributing circumstances, and how the family attempted to deal with it.

Step 4: Assess Strengths and Needs

Family assessment of strengths and needs begins immediately and continues throughout crisis intervention. The crisis worker draws conclusions regarding the family's strengths and needs related to the current crisis and, with the family, evaluates the potential for recovery. Client strengths are tapped to improve self-esteem, while also providing energy and skills for problem-solving.

Step 5: Formulate a Dynamic Explanation

This step looks for an explanation not of *what* happened, but *why* it happened. This is the core of the crisis problem. The meaning of the crisis and its antecedents as seen by the clients are explored. Why do they ascribe that meaning or perceive it as they do?

Step 6: Restore Cognitive Functioning

In this step, the crisis worker helps the family identify alternatives for resolving the crisis (i.e., reasonable solutions toward which the family is motivated to work).

Step 7: Plan and Implement Treatment

The crisis worker assists the family in the formulation of short- and long-term goals, objectives, and action steps based on what the family chooses as priorities. With a concrete plan of action, the family feels less helpless, more in control, allowing members to focus on action steps. Objectives and action steps need to be simple and easy at first, assuring client success. The family members are responsible for action steps or homework, but the crisis worker continues to counsel them, seeks to help find appropriate resources in the community, and becomes the family's advocate.

Step 8: Terminate

Termination occurs when the family achieves its pre-crisis level of stability. Crisis workers review with the family the precipitating event(s) and response(s) and the newly learned coping skills that can be applied in the future. The crisis worker assures that the family is scheduled for meetings with, and committed to, any necessary, ongoing community services.

Step 9: Follow-up

Crisis workers arrange for continuing contacts with families and referral sources on predetermined dates or by saying "I'll be contacting you soon to see how you are doing."[14] This puts appropriate pressure on families to continue to work on issues in a positive way.[15]

CRISIS INTERVENTION TEAMS

In cases involving child abuse or neglect, there is frequent misunderstanding about the differences among investigation, psychological first aid, and rehabilitative crisis intervention. Each, however, plays a critical role in a team's response to child maltreatment. Ultimately, rehabilitative crisis-intervention skills can significantly enhance investigative or psychological first-aid approaches.

Investigation

The purpose of the investigation is to determine whether child abuse and neglect exist within a family reported to the CPS agency, to interpret the agency role, to determine whether the family will benefit from further intervention, and to assess whether there is a risk that future maltreatment will occur.[16] As noted in an earlier user manual, *Child Protection Services: A Guide for Workers*, "[investigative] intervention should be timely, limited to required procedures, and terminated when it is determined that continuation is unnecessary or when services are no longer required."[17] Whereas emergencies should receive immediate response, nonemergency situations can be contacted within 24 hours, and can usually take place in the child's current residence.

On the basis of the CPS investigation and case assessment, crisis workers must decide if the case warrants continued intervention. At this point, crisis workers may need to use crisis-intervention techniques. Removal of the child is not the primary objective, but rather the alternative, if intervention fails and the child cannot be protected in the home.

Psychological First Aid

Psychological first aid, or helping to reduce anxiety by listening and reassuring the family, is critical to the establishment of rapport. This requires hours of listening on the part of crisis workers.

Psychological first aid may also be a one-time intervention offered by neighbors, relatives, churches, or helping agencies that provide money, food, housing, or transportation. Although this support system is extremely important in the overall crisis response, it does not teach clients to problem-solve and, in fact, may leave the clients to struggle with repetitive crises.[18]

If possible, crisis workers need to persuade community support systems to stay involved with the family after the initial crisis period, going well beyond the psychological first aid stage. Establishment of consistent friendships and other community supports can help avert future crises.

Rehabilitative Crisis Intervention

As Slaikeu states in *Crisis Intervention: A Handbook for Practice and Research*, rehabilitative crisis intervention aims to help "the client deal with the impact of the crisis event in all areas of the client's life."[19] Through resolution of one crisis, the client can gain skills for facing and solving future problems, rather than developing a repetitive cycle of being "rescued" from similar crises.

This does not mean that the primary focus is on all areas of the client's life. Instead, by staying focused and being successful in problem-solving, clients learn skills that are transferable to all areas of their lives and can be used to resolve future crises. Even though the focus is on current problems, many clients come to understand how past, unresolved trauma contributed to maladaptive attempts to solve the present crisis.

OVERVIEW OF TEAMS RELATED TO CPS

Whenever a CPS investigator believes that a child's safety in the home is questionable, and that intensive, in-home intervention services are needed to protect the child from harm, a crisis-intervention team should be called in right away. CPS and specialized teams should always cooperate, not compete, since investigation and treatment are separate, equally important functions.[20]

The team concept is critical in shaping the philosophy and vision of family preservation or other crisis-intervention programs. The combined knowledge of a multidisciplinary team provides for more accurate assessment and treatment approaches, and more varied use of community resources. Furthermore, there is strength in numbers, meaning that a team provides safety or protection for its members as well as the families that are being helped. The likelihood of violence, or even resistive behaviors, is reduced when a "team" is present.

A dysfunctional family system is also more likely to be positively influenced by an intervention system, a team, that demonstrates clear and honest communication, as well as respect, among team members. Team members should have diverse knowledge and skills. Those with highly specialized knowledge, such as child development or substance abuse assessment, may serve as consultants to other team members.

When a multidisciplinary crisis team is unavailable, as in small communities, close contact must be maintained between the crisis worker and the supervisor or consultant, who work together as a small team.

SPECIALIZED, MULTIDISCIPLINARY TEAMS

Multidisciplinary crisis-intervention teams bring specialized knowledge to a crisis situation. To be effective, each crisis worker plays a distinct role, with a coordinating supervisor providing support and overall direction. Team members may be in a direct service role or that of a consultant to other crisis workers. Preferably, team members represent both sexes and a range of chronological and professional development stages. When more than one team member goes to a home or multidisciplinary interview center, a lead crisis worker needs to be in charge to assure that goals for the visit or interview are accomplished.

Some crisis workers excel at using community resources or providing concrete services. Others excel at assessing problems, helping families communicate better, or listening in a way that makes families willing to talk openly. Some crisis workers are especially good at accompanying clients to a well baby clinic, to a physician's office, to prospective employment, or even the grocery store, thereby helping them feel successful in accomplishing a task. Some crisis workers are better at supportive confrontation or placing limits on inappropriate client behaviors. Drawing on each team member's strengths greatly enhances service delivery.

Time limits of service, 24-hour availability, and belief that clients have the skills with which to solve their problems are essential. Time-limited service requires advanced planning, specialized knowledge, and specific skills if families are to benefit. The following are areas that any program providing a team approach must address in order to assure the team's effectiveness:

- clarity regarding crisis workers' specialized, multidisciplinary roles;
- development of an eclectic base of theoretical and intervention knowledge;
- training and supervision to assure that crisis workers and clients stay focused on the chosen goals;
- specific training regarding crisis intervention theory;
- consistent and timely supervision to enhance skills and provide support;
- debriefing by a supervisor and peers to prevent the team's burn-out; and
- training which addresses crisis worker safety and vulnerability.

CRISIS AS AN OPPORTUNITY TO INITIATE CHANGE

If help is not available when a family is open to new ways of coping, family members may sink deeper into maladaptive patterns such as more violence, heavier substance abuse, deeper withdrawal, or more destructive scapegoating. Under such circumstances, there is increased risk of child abuse and neglect.

When individuals and families are highly stressed and anxious about dealing with unfamiliar problems, such as a summons to appear in juvenile court, they may feel overwhelmed, hopeless, and panicked. After attempting to use responses that have worked for them in the past, they are searching for new responses to their dilemma. If, in the past, they have responded to frustration by yelling, accusing, hitting, feeling sick, withdrawing, or crying, it becomes evident to them that these responses are not stopping the CPS or law enforcement investigation. Finding

no answer to the situation, while perceiving a threat to their existence, families are open to new ways of processing and resolving their problems.

During the resolution of a crisis, individuals and families tend to be particularly amenable to help. Customary defense mechanisms weaken, usual coping patterns prove inadequate, and the ego becomes more open to outside influence and change. A minimal effort at this time can produce a maximum effect; a small amount of help, appropriately focused, can prove more effective than more extensive help at a period of less emotional accessibility.[21]

If an immediate therapeutic response is made while the family is still experiencing a high level of anxiety or emotional pain, the family is more receptive to intervention. Therefore, the crisis worker must listen closely and determine what the family wants to change. During this emotional, rehabilitative, goal-setting period, crisis workers should:

- respond to family members' disorganized thinking and feelings of guilt, fear, or anger by focusing on one to four critical issues (goals), thereby increasing their ability to manage their feelings and circumstances;
- help families explore their coping mechanisms and identify alternatives for coping with crises, thereby reducing impulsiveness, feelings of vulnerability, and helplessness;
- assist the family in using additional community supports, thereby reducing isolation, enmeshment, dependence, and the complexity of interrelated problems.[22]

CRISIS INTERVENTION AS A PLANNED RESPONSE

Since there is a window of opportunity during which families are open to change, effective crisis intervention is timely in its response and diligent in assuring safety for the children and other family members. A helpful, planned response includes:

- providing immediate contact, within 48 hours or less;
- staying with the family as long as necessary to stabilize the immediate crisis;
- being available 24 hours a day, 7 days a week;
- providing assessment and services, at least in part, in the home;
- maintaining small caseloads, usually two or three and no more than 13;
- having daily contact with the family in the beginning and decreasing the contact gradually;
- setting a predetermined length of service, usually 4 to 12 weeks;
- listening actively for long periods, focusing clients on one to four critical problems or goals;
- providing counseling, concrete services, and community resources;
- believing that a crisis makes people open to change for the better;

- encouraging the family to set its own goals with limited guidance from crisis workers;
- maintaining time-limited intervention;
- focusing on the total family system, but maintaining flexibility in working with whoever is available; and
- providing a team approach, even if some members are used exclusively as consultants.

Presence Until Stress Is Reduced

It is important to note that the crisis worker must be present until family stress is reduced and the child is safe. Seldom can only one visit provide such safety. For resolution, most crises require several visits. Certainly this is true in families where there are linkages to unresolved past crises and where the child's safety may be in doubt.[23]

Some families seem to be crisis prone, always living on the brink of another crisis. At least one author has referred to "exhaustion crisis," in which persons under consistent stress are finally overwhelmed by an additional internal or external stress, and "shock crisis," in which there is no forewarning prior to a sudden change in the social environment.[24] Chronically dysfunctional families who are reported for child abuse and neglect could fall into either category. "Stresses become traumatic through repetition."[25] Consequently, some families are overwhelmed not only by abuse or neglect but also by repeated inquiries into their abusive or neglectful patterns. These families may need ongoing services for a period of 2 to 5 years, or parental rights may need to be terminated when sadistic and torturous abuse is present.[26]

It is possible that multiple crises in families as a way of life may be an attempt to avoid emotional pain from the past and to test crisis workers' commitment and trustworthiness. Crisis workers should not promise more than they can deliver in the prescribed time limit, but arrangements for long-term intervention can be part of the crisis-intervention plan.

SUMMARY

In summary, a family is most likely to accept intervention from "outsiders" during a state of crisis. In contrast to traditional casework, crisis intervention is brief in duration, focused primarily on the "here and now," and supports family members in what they—not the crisis worker—want to change.

A skillful crisis worker or crisis-intervention team involves the entire family in the problem-solving process, reinforces the family's abilities and strengths, and conveys a hopeful attitude to the family about problem resolution. Concrete services are provided to lessen pressures in the family and to free the family's energy for setting and achieving goals. Prior to termination of crisis-intervention services, skillful crisis workers make sure the family is linked to the resources it needs in the community and then formalize a plan for follow-up.

Many families known to CPS agencies have multiple problems. It is important to remember that crisis workers are not responsible for helping families solve all of their problems. Rather, the task is to help families stabilize and learn to focus and find solutions to a limited number of problems. In that way, families gain a sense of accomplishment and success, encouraging them to move on to solving other issues, either on their own or with the help of resources in the community.

CRISIS INTERVENTION ASSESSMENT

INTRODUCTION

Different personalities of individuals, the divergent environments in which they reside, the variety of psychological and biological make-ups, and the varying family structures in which they live lead to a broad range of responses to stress. Consequently, it becomes difficult to predict human behavior.[27] Yet it is necessary to make an attempt to assess the risk of abuse within families in order to protect family members.

People in crisis need, and are more responsive to, immediate intervention. (Rapport, necessary for family assessment, is more readily established by offering immediate emotional first aid and support when the family is frightened, confused, and experiencing emotional pain.)

A case of father-daughter incest illustrates the stages of crisis intervention. The multidisciplinary team learns that a hazardous event occurred when the father lost his job and received criticism from his wife. He felt or perceived himself to be in a vulnerable state, with the family not respecting him. He turned to a child in the family who seemed most understanding and least likely to reject him. Sexualizing his needs and feelings for the child, he misused his power by sexually fondling the child (precipitating factor) who, in turn, told a friend (hazardous event) who told a school authority. The case was reported (vulnerable state), followed by an investigation (another precipitating factor). By this time, the family was in an active state of crisis.[28] Note that there can be several, cumulative precipitating factors and successive crises in one family. (In no way does this example imply that sex abusers are not fully responsible for their perpetration.)

TOTAL FAMILY INVOLVEMENT

Since families are systems, what affects one member of a family affects other members. Considering this dynamic, interactional pattern, it makes sense to involve the entire family in crisis-intervention assessment. This is especially true in child abuse and neglect cases where the interactional pattern is dysfunctional, and change is critical to protecting the child. Even in incest cases or illegal drug sales, in which the offender is removed but reunification may occur, intervention is done with remaining family members but coordinated with professionals who are treating the offender.

For an intervention to be most effective, all family members require both individual and group attention. Each member needs to feel special and separate, yet an integral part of the family group. Individual and family value orientations, communication styles, and roles must be understood. It takes hours of listening for the crisis worker to understand implicit family rules and beliefs, how messages are communicated and received, and who relates to whom and how, within the family.

All family members need the opportunity to give their opinions about the family's primary problems. Different opinions help the crisis worker get a picture of the antecedents to the crisis. The involvement of the total family may facilitate the following intervention.

When family crisis intervention is implemented, the specific steps that follow—similar to the generic stages of individual or group crisis counseling—should be taken. Appropriate efforts should be made to involve family members in each phase, which are to: (1) search for the precipitating event and its perceptual meaning to the family

members; (2) look for the coping means used by the family and appraise the extent to which these have or have not been successful; (3) search for alternative ways of coping and the resources that might improve the situation, while actively soliciting suggestions from family members; (4) review and support the family members' efforts to cope in new ways, with evaluation of results in terms of day-to-day living experiences; (5) move toward early termination that was planned in the initial contract with the family; and (6) plan and conduct at least one follow-up or "booster-shot" session. Throughout this process, the crisis worker should actively define the goals of the family crisis session and the means that can be used for goal achievement, while energetically focusing on the relevant issues.[29]

ASSESSMENT

While making an assessment, an crisis worker pays special attention to the initial contact with the family, what events precipitated the crisis, family interactions and conditions, and the family's perceived needs. With such understanding, crisis workers can more adequately assess risk to the child or children.

Making the Initial Contact

Before making contact with families, crisis workers should not pre-judge them, no matter what information is available from other sources. By keeping an open mind, crisis workers may see and hear things never perceived by other "helpers" and start afresh.

The initial contact capitalizes upon the family members' search for answers to the crisis. Intervention must occur before the family members find rigid, maladaptive ways to defend themselves against the outside world. At this point, they are ready to receive open-minded, honest, trustworthy crisis workers.

Kinney, Haapala, and Gast, experienced crisis workers, suggest the following approach during the initial contact:

> We find it most helpful to plunge right into each client's version of his/her family's problems. Clients become motivated if we follow their agenda. They have the best knowledge of the situation and of constraints that should be considered in proposing treatment options. Clients can help organize the information to suit their experience instead of relying on the therapist to organize information to fit his/her idea of their experience. They give enormous amounts of information when they are really "hurting."
>
> We find the most useful tool in this process to be active listening.... An active listener reflects feelings and content of what the client is saying. He/she avoids questions, interpretations, and advice giving. When therapists use this technique, clients rapidly begin sharing more than superficial information. They begin to like and trust the therapist. They will probably be more likely to try options he/she suggests later.
>
> In many cases, active listening is all that is needed for problem resolution.[30]

Careful listening will usually facilitate understanding without trapping the crisis worker in initial judgments.

Identifying the Precipitating Event

Frequently in crisis intervention, the CPS investigation may be the precipitating factor for a new crisis for the family. But, prior to that, the precipitating factor, or presenting problem, was the physical abuse, sexual abuse, or neglect of a child, or possibly a child's observation of violence between adults. The crisis worker from CPS or another crisis intervention program needs to explain why he or she is there, what information he or she has been given, and explain that he or she is there to listen and help, not to blame or accuse. Consequently, the crisis worker

may get new information, both current and past, regarding the crisis and its antecedents. The family can thereby set goals for resolving the current crisis and preventing similar crises in the future.

Observing Family Interactions and Conditions

Observation skills are critical tools for the crisis worker. The most important observational skill is that of seeing a crisis through the eyes of the client. This means that the worker has objective, nonjudgmental empathy. Much attention is given to nonverbal communication, and an attempt is made to understand family members' feelings toward each other and toward the crisis worker.

Good observers try to determine more than surface appearance. For instance, the poorly kept house or unkempt person may signify depression or even physical illness. An orderly existence may be impossible for overworked parents who have several young children. Such conditions do not indicate whether or not there is appropriate affection between family members. A nurturing attitude may be of greater value to children than a clean living room! A hostile client may be reacting to negative experiences with social agencies in the past.

The crisis worker must understand child care practices in various cultures.[31] Crisis workers from middle-class backgrounds must try to understand the stresses of living in poverty, including the fear of violence in the ghetto and the temptation to sell drugs to support the family. A crisis worker's being naive or not being "street wise" can interfere with his or her observations. There may be signs of child sexual abuse, drug dealing, spouse abuse, or mental illness that are subtle or different from the crisis worker's experience. For purposes of getting supervision or consultation from other team members, the good observer merely describes with detailed objectivity the what, when, where, and how of the home visit. Good descriptive material is always clear, whereas use of labels and conditions such as "rigid," "resistive," and "paranoid" are subjective and potentially biasing. In fairness to crisis workers, good listeners and observers are not able to recall every important occurrence or statement that comes forth during several hours of emotional intensity, but a good listener and observer does remain objective.

Determining Family Needs

Traditional therapies and casework tend to determine what the family's problems are and what the family members must do to change. In contrast, crisis intervention encourages families to determine what their problems are, what they want help with, and how they want to go about making changes. The family chooses a limited number of goals, hopefully no more than four, from a more extensive number of possibilities, and determines action steps for achieving the goals. The crisis worker helps the family stay focused to achieve these goals.

To be successful in focusing families, crisis workers need to have a sense of compassion, flexibility, and responsiveness to slight changes in focus. Rigidly adhering to a course of action brings greater pain and disappointment. For instance, a family member may have chosen to search for employment outside the home but can only find minimum-wage work that barely pays for transportation, clothing, child day-care, lunch, and other job-related costs. Consequently, the goal may need to change, such as doing piecework at home, possibly arts and crafts, or switching to a goal for part-time work when a spouse or relative can provide child care.

Misperceptions of clients and what they need can create new crises. For example, lack of understanding of Native American culture has created unnecessary removal of children who, in turn, became disconnected from their culture and yet not integrated into any other culture.[32]

With any family, not just culturally different or minority families, an insensitive crisis worker can make incorrect assumptions. Personal values and past experiences can bias one's perception of families and limit recognition of

possible interventions. Ultimately, crisis workers must listen closely to the family members' perceptions and respond to their needs, not their own personal needs or wishes.

ASSESSING RISK

Risk is defined as the likelihood of maltreatment occurring in the future. Safety is the determination regarding the immediacy and severity of the risk. Therefore, crisis workers must first determine whether the maltreatment is likely to occur again, and then determine if the child is safe. Extensive information on risk assessment is provided in another User Manual Series publication, *Child Protective Services: A Guide for Caseworkers*.[33]

In evaluating a family, the child's safety is of uppermost importance. Can the child be protected while crisis intervention services are being delivered? At the end of crisis intervention, will the child be in imminent danger? Is the criminal behavior in the family so prevalent that the child can only identify with criminal activity? Is addictive behavior such that the child only sees immediate gratification through drug use, sex, gambling, and other addictions? Are the addicted members willing to enter drug treatment? Are the addictions, drug dealing, and other criminal behaviors more important to the family than the children are? Realizing that the children may be removed, do the adults still refuse to cooperate in looking for mutually acceptable goals for change? Can the crisis worker engage just one adult in the assessment and planning? If so, there is still hope for change.

If it is determined that the child is not safe in the home, then it is incumbent upon the crisis worker to determine first whether crisis intervention will assure the child's safety in the home. If it cannot be assured in the home, then the child must be removed for his or her own safety. For instance, removal of a sex abuser may not assure a child's safety if the remaining parent has been intimidated by the offender and will not protect the child or other children. Nonoffending parents who were sexually abused as children may have low self-esteem, dependency, or even flashbacks that reduce their ability to protect children or themselves.

Another way to look at risk assessment is to see it as determining whether the child is happiest with extra protection in the home or removal from the home. Many children are reluctant to leave home or to want removal of the abuser because they fear the unfamiliar. If a child asks to be removed, careful assessment is needed. Is the child truly in danger, or has the child learned to manipulate away from discipline, believing there is less or almost no discipline in out-of-home placement? In the latter instance, parents may need help in applying consistent, firm, nonviolent discipline such as time-out, grounding for short periods, consequences for inappropriate behavior, and other good behavior-management approaches.[34] Nevertheless, when a child asks to be removed, thoughtful consideration must be given.

A more specific criterion is that of sadistic or torturous maltreatment, which suggests that parental rights may need to be terminated. This is true in other cases with parents who have made no significant changes in 6 to 12 months of intervention and treatment as well.[35] Of course, these parents should not be blamed for ineffectual therapy. From the beginning, they deserve, and should have, well-trained, solution-focused professionals. If this kind of effective treatment system is absent, the parents and children may deserve a further chance to avail themselves of treatment.

From a practical standpoint, removal of a child does not always assure safety. Some youths are physically or sexually abused in out-of-home placements. Others are so distressed that they run away or act out in other ways. Their hurt and their rage are misunderstood and require careful evaluation.

Most children and families just need better-trained crisis workers. Program models, such as those described in the "Family-Centered Crisis Response Models" chapter of this manual, report between 70 and 90 percent success in keeping youth safe in their homes. This suggests that only the most severe, most sadistic abuse requires removal

of the abuser or the victim, with the victim being removed only when the severe abuser breaks court orders and returns home or threatens to harm the child.

SCREENING INSTRUMENTS

Great caution and professional judgment are warranted in the use of any risk-assessment protocol. Generally, a constellation of risk factors, rather than only one risk factor, suggests that the child is not safe or that vigilant monitoring is advised.

When used properly, screening instruments such as the Child Abuse Potential Inventory for parent screening and treatment evaluation or the Child Maltreatment Interview Schedule can be helpful. Training in the use of such instruments is required, however, to assure that misinterpretations do not occur.[36]

There are both general and specific forms and lists that have been developed but require much further research. For instance, there is the Family Assessment Form (FAF), designed to assist in-home workers in determining what intervention is needed.[37] The risk variables are measured by the Family Risk Scales, a total of 26 scales with sub-variables, and "emphasize parental characteristics and family conditions that are believed to be predictors or precursors of child maltreatment or other harm to children."[38] It also incorporates six of the Child Well-Being Scales, referenced below, which are believed to be most useful for risk assessment.

Even though general risk-assessment checklists must be used with caution, they may be helpful as reminders of the great variety of possibilities to be studied in determining risk in cases of child abuse and neglect. They are of benefit in preparing for supervision and consultation as well, assuming that the crisis worker's listening and observing take precedence over the rigid filling out of checklists.

Since checklists tend to identify weaknesses in families, crisis workers are cautioned to work harder at finding strengths and building on those, while seeing family weakness as potential goals or action steps in reverse. An example is that of the parents' lack of nurturing or quality parenting skills. If parents feel that they want to improve in this area, a goal becomes: "Parents will develop positive nurturing and parenting skills." Action steps may be: (1) "Attend child development sessions once weekly" or "Spend 30 minutes daily with crisis worker learning child development stages;" (2) "Learn and practice behavioral management techniques with crisis worker;" (3) "Learn how to express appropriate, nonsexual affection and practice in presence of worker." Parents' desire to work toward such parenting goals is a positive indicator during the assessment period.

Some authors emphasize tendencies of abusive parents. When assessing the risk of maltreatment, they focus on parents who are more likely to pose a danger to their child because they:

- deny responsibility for their actions;
- blame their victims;
- do the opposite of what they advocate;
- need to dominate their children;
- deeply mistrust their children;

- obsess about their needs, not their children's needs; and
- repeat abusive acts compulsively.[39]

Child abuse and neglect assessment is an attempt to calculate the probability of risk, knowing there is no fool-proof approach to protecting all children. But risks of harm are greater when certain factors come together. For instance, David Finkelhor's "Eight Risk Factors for Sexual Abuse" indicate that children in the following situations are vulnerable to being sexually abused:

- step-father in the home;
- victim has lived without a mother at some point;
- victim is not close to mother;
- mother did not finish high school;
- mother sexually punitive toward child, meaning hostile about any of the child's sexual issues;
- no physical affection from father;
- income under $10,000; and
- child has two friends or less.[40]

Crisis workers can assess whether the above factors are present and whether offsetting safeguards are in place. Further examples of risk scales are the "Child Well-Being Scales" for child neglect,[41] and "The Wife Abuse Inventory,"[42] and the "Substance Abuse Subtle Screening Inventory."[43]

ASSESSMENT OF OTHER SPECIAL ISSUES

Crisis workers improve services to families by studying and assessing the presence or absence of suicide potential, post-traumatic stress disorder, and sex offenders' amenability to treatment.

Suicide Potential

Both victims and abusers have been known to commit suicide when they perceived no other appropriate solutions. Any past suicidal gestures or current statements require careful consideration by the crisis worker. Likewise, any family member who seems despondent or overwhelmed by anxiety needs specific assessment of suicide potential. Individual family members whose affect is inappropriate for the circumstances may need evaluation as well. Because more children and adolescents are committing suicide in this country than in the past, professionals need to be sensitive to these tendencies during a crisis.[44] There are various suicide scales which should be part of the intervention team's repertoire for assessment.[45]

Post-Traumatic Stress Disorder

Children who have been abused or have witnessed abuse in the family often suffer from post-traumatic stress disorder (PTSD),[46] which requires a four-step approach to intervention:

- recognize the symptoms of violence-related PTSD;
- determine how the child has already tried to master the anxiety or avoid its recurrence;
- determine the influences or factors which are facilitating or preventing trauma resolution; and
- decide if the trauma resolution is interfering with normal childhood tasks or propelling the child into more adult roles.[47]

Sex Offenders' Ability to Change

Assessment of a sex offender's honesty, remorse, denial, minimization, use of force, premeditation, family enmeshment, substance abuse, past victimization, empathy or motivation for change, and age is necessary in determining the appropriate interventions for the offender, victim, and family members.[48] Total family involvement is required for successful intervention. Chronic offenders need long-term monitoring and strict supervision. Risk to the child is very high when the mother doubts the child's story of victimization.

When Assessment Indicates a Lack of Safety for Children

When children cannot be protected in their homes, one solution is to obtain a court order requiring that the adult leave the home. If other family members and the abuser are likely to collaborate in defying the plan, putting the children at risk, then removal of the children from the home is necessary.

Another option is to bring protective relatives to the children's home while their parent(s) leaves the home. In certain instances, such as when both parents are on drugs and have to be removed temporarily and protective relatives are not available, a 24-hour homemaker and crisis worker may be needed in the home.

Until a decision is made about whether the parents have the potential and desire to care for the children, it is best to keep the children in the familiar environs of home. There are various options for accomplishing this, such as asking the abuser to leave the home or bringing 24-hour caretakers to the home.

Removing children from the home is traumatic for parents and children, even when all agree it is best. In fact, removal creates a new crisis for everyone involved. Techniques of crisis intervention, described in the next chapter, are beneficial in reducing the separation anxiety which accompanies emergency placements.

If the parents are available, try to involve them in the decision to leave the home or to place the children in emergency placement. Likewise, to the extent possible, children deserve to be involved in the decision, based on their age and ability to assess their situation. Many maltreated children can feel reasonably good about being placed with caring and protective families, but will need a great deal of support and reassurance about what the future appears to be. Young children and severely intimidated youth may be unaware of their rights. They may not understand that nonintimidating lifestyles are possible. They may want to cling to the abusive family even when it is chaotic and incapable of protection or nurturance.

With the dramatic increase in the number of children being placed with relatives, crisis workers must exercise caution to assure children's safety, as relatives may have come from similarly dysfunctional backgrounds. Furthermore, children in kinship care deserve the same supports that are afforded to children in the legal custody of the State.

Children's anxiety and loneliness are greatly reduced when they can be placed along with siblings, familiar toys, clothes, bedclothing, animals, and other familiar objects. Crisis workers can advocate for such consideration of the children's feelings.[49]

Because children are prone to blame themselves for abuse and separation from the family, they need much reassurance that they are not to blame. To the extent possible, the crisis worker should review the anticipated happenings of the next few days and how the child's safety and protection will be managed. Children need reassurance that they will return to their parents when, or if, it is safe.

It is important for crisis workers to find strengths in the parents even if their behaviors are unacceptable. Crisis workers need to listen to the parents' frustrations and anger and help them choose reasonable goals for reunification with their children. Plans for supervised visitation with the children and an agreement for ongoing counseling are desirable after the parents have expressed and learned to cope with their anger toward the child placement agency.

SUMMARY

If possible, crisis-intervention assessment involves all family members, both individually and as a group, to determine family interactions, conditions, and events that precipitated the crisis. Having no preconceived notions, the openminded crisis worker allows the family to determine their needs and their goals for change.

Immediately and longitudinally, the safety of the children and other family members is considered. Although there are no foolproof screening instruments or checklists, such tools can assist in calculating the probability of risk for additional abuse or neglect and the presence of individual and family strengths for change.

CRISIS INTERVENTION TREATMENT APPROACHES AND TECHNIQUES

INTRODUCTION

The following sections on eclectic knowledge, staying focused, treatment approaches, and techniques explain how to work with families beyond the initial assessment phase. A team approach to crisis intervention is desirable because each team member can develop some expertise in one or more of the following theories and in the best techniques to be used with differing client populations and crisis situations.

ECLECTIC KNOWLEDGE BASE

No one crisis intervention method will work with all clients, or even all the time with any one client. There are many different family structures, compositions, and culturally related belief systems. The eclectic crisis worker tries to understand and respect these diversities in families.

In this chapter, various interconnecting theories are mentioned as they relate to an eclectic practice base. Practitioners must be flexible and willing to use any theoretical approach or technique that will work to benefit and stabilize a family in crisis. Articles and books have been written about the efficacy of eclectic practice in working with families.[50] Such a viewpoint is expressed by the following quote from *Crisis Intervention Book 2: The Practitioner's Sourcebook for Brief Therapy*:

> The crisis counselor's basic task is to help clients change those affective (feeling), cognitive (thinking), and behavioral (doing) patterns that hinder effective value clarification and rule making and to encourage constructive communication and appropriate role behavior. Thus, it is essential to develop a judiciously eclectic approach that attends to these domains of human functioning (feeling, thinking, and doing) in order to help persons in crisis mobilize the resources that will unblock and enhance performance in these vital areas.[51]

Concrete services complement rational-emotive therapy,[52] behavioral therapy,[53] or any theoretical approach. Environmental stresses and lack of resources add to the family's feeling of being overwhelmed. Concrete services, which lessen the pressure in one area of the family's life, can free energy for setting and achieving other problem-solving goals.[54]

ABILITY TO FOCUS SELF AND CLIENTS

Sometimes the major stressors in a family may be rather obvious, and it is merely a matter of helping the family focus on one problem at a time, such as applying for food stamps and looking for a better paying job because family income is insufficient, perhaps contributing to these quarrels and violence. In addition to focusing on food stamps and employment, there must also be a focus on stopping the abuse, which requires development of anger-management skills, appropriate channeling of anger, more open and respectful communication of feelings in the family, and enhancement of the adults' relationship. In the above example, there may be only two goals: (1) Improve family income resources and (2) enable parents to use disciplinary practices that do not harm the child. Both of these goals require several action steps, but the focus of intervention remains on the two goals. After the

intervention ends, additional anger-management work may be sought through therapists who provide such individual or group treatment.

On the other hand, some families have a multitude of stressors, some chronic and some acute, plus the accusation of abuse or neglect. The family may bombard the crisis worker with medical, legal, financial, housing, transportation, and school-related problems. The crisis worker can easily feel overwhelmed and want to begin working on all problems at once. That is a perfect formula for failure, because there will not be enough time and energy to do everything. As one family said, "We were trying to work on everything at once because we thought we had to fix it all in order to be acceptable people. We had a lot of agencies working with us, and each one wanted us to change something. Nobody ever told us to focus and fix one thing before going on to another."

Crisis intervention, like brief therapy, focuses on helping the family choose their goals and how they will go about attaining them. The crisis worker may feel that other problems are more important, and it is acceptable to discuss them, but what is finally chosen as the primary concern should be clearly the family's choice. This approach empowers the clients with the feeling that they can be in charge of their destiny. For instance, if the family members complain about each other and various agencies, the crisis worker should encourage them to explain what they would like to change that is within their control, as opposed to changing the agencies. In other words, encourage them to redefine a complaint as a goal.[55] Many clients waste their energy trying to force others to change, rather than concentrating on the one thing within their control, themselves. Once the primary goal, and maybe one to three others, is established, every meeting with the family will focus on the goal. Homework between meetings should clearly focus on the goal as well.

It is essential to listen closely for what is important to the family. What ideas do they have for finding solutions? This is a good predictor of success since a focus on the family's concerns can free new energy for finding solutions to other problems, one or two at a time. The family also learns to think flexibly in a problem-solving mode, thereby increasing their confidence regarding ability to cope with future stress. To assure this sense of mastery, the crisis worker should take time to "celebrate" or enjoy each accomplishment with the family.

APPROACHES

Integration of various approaches is required to help families accomplish their goals. These approaches, as described below, include: community system and use of community resources; multiple impact or multimodal; cognitive-behavioral or rational-emotive; task-centered; family treatment; and eclectic.

A "Community Systems" and "Use of Community Resources" Approach

Total family involvement is of paramount importance to crisis intervention. Similarly, successful crisis workers find that coordination and involvement of all available community agencies and resources are of paramount importance to successful resolution of most crises. System-centered or person-in-situation perspectives place less emphasis on pathology and more on the interaction of the client with environmental systems.

When addressing the needs of families in crisis, close cooperation between community services assures the maximum benefit from utilization of resources. Poor communication and lack of coordinated efforts between health, legal, social service, education, volunteer, and church-related resources can create extreme frustration for families who are in crisis. For instance, many clients have grown to distrust agencies that promise cooperation from other organizations. Often, they have been told that an agency would help, only to learn that they are ineligible, must go on a waiting list, must subscribe to the helper's value system, or must accept a substitute service. Even worse, some clients have been criticized and humiliated for not understanding agency eligibility requirements.

To provide stability and consistent support for families, crisis workers can guide them to appropriate organizations and services, but it helps when crisis workers give the name of a specific person rather than simply a telephone number. During the initial crisis, crisis workers may even need to accompany the clients to appointments. As the family begins to stabilize, members can be expected to take more individual initiative. As a support system, the crisis worker should always be available by phone or beeper. Advocacy for clients, helping them access and use resources, dramatically enhances the therapeutic relationship.

Abusive families' diverse needs require services from a plethora of organizations, since no one agency controls and delivers investigation, crisis intervention, concrete services, long-term treatment, and the variety of health, social, legal, housing, education, employment, mental health, spiritual, welfare maintenance, and other necessary service components for successful crisis resolution. So-called "wrap-around" services provide whatever the family thinks it needs in order to stabilize. Obviously, this requires strong, collaborative efforts among community resources. As Fandetti states in *Issues in the Organization of Services for Child Abuse and Neglect*, "Children at risk of placement because of abuse and neglect require tight rather than confused and loosely organized networks of service, interlocked rather than fragmented services and agency policies."[56]

Respite child care from a parent aide, day-care placement, a baby sitter, or recreational agency placement may give the parents the free time needed for relief of tension and time to focus on themselves. Medical attention, Alcoholics Anonymous or Narcotics Anonymous meetings, or a contact regarding better housing may reduce day-to-day stress. Development of a joint service treatment plan with the family, CPS, and other crisis workers demonstrates how various resources can cooperate to everyone's satisfaction.

Throughout crisis intervention, the crisis worker must make repeated contacts with other providers. Division or disagreement between agencies will feel like rejection to clients who experience chaos and disorganization not only as emotionally hurtful but also as irreversible.

The crisis-intervention team, a child and family advocacy organization, or a social service agency needs to assume leadership in bringing community organizations together to develop trust and exchange information on missions and programs. If possible, a community committee should be developed to study gaps in services and coordinate existing services. This is more a responsibility for administrative personnel, but every person who is concerned about families in crisis needs to advocate for coordination and collaboration and participate in both formal and informal coordinating committees.

The Multiple Impact or Multimodal Approach

The value of the multiple-impact approach, using many crisis workers, has been recognized for well over a decade,[57] as has the efficacy of a generalist-specialist team for dealing with family and community-wide dysfunction.[58] The generalist-specialist team model incorporates professionals with specialized training, such as child development, sexual abuse assessment, or behavioral management, along with team members who are broadly trained so that consultation is maximized for all team members. Ultimately, to be effective, the team needs to maintain strong relationships with public and community service systems which address additional child and family needs.[59]

Several programs have demonstrated that multiple impact and multimodal interventions are effective with even the most chaotic families.[60]

Multiple Impact Therapy (MIT) assigns therapists, students, or volunteers to each family member for an hour or so of assessment and on-going treatment. The initial session may be with the entire family and with the many therapists assigned to each member, and there may be some individual time spent with specific family members.

Ultimately, all family members and all therapists come together. Family members may be asked to observe while each therapist role plays a family member, who sits by the therapist, saying what the family member feels and wants from other family members. If a family member feels misrepresented, a timeout may be called for consultation with the therapist who is representing him or her. The therapist uses "I" messages to express how things in the family look from his or her perspective as a family member. This process takes several hours since family members are encouraged to say how they feel, what else they want to clarify, and what they want to work on in the future.

For crisis treatment beyond the first day or two, only one crisis worker may be assigned or, if it seems necessary, more than one. This is when well-trained students or volunteers can be an extremely cost-effective part of the continuing process. Even if only one crisis worker is assigned for ongoing treatment with the family, there is now a cadre of consultants who know the family from firsthand experience.

Some authors find that "the literature clearly indicates that multimodal interventions tailored to the subjects' deficits should be implemented rather than [provision of one type of program (e.g., parent education)] that emphasizes one or two factors for all abusers." They add that family, community, and social supports are part of adequate interventions.[61]

Cognitive Behavioral Approach

Clients' belief systems and their thought processes can contribute to their abusive or victimized behaviors. Cognitive behavioral therapy assumes that clients have irrational, maladaptive beliefs that require cognitive restructuring.[62] Behavior therapy is effective in child management, parenting, and parent training and, more recently, in shaping adult behavior. Many authors have outlined specifics of behavioral assessment and treatment.[63]

Briefly, cognitive behavioral therapy is designed to identify specific, undesirable target behaviors through listening to the opinions of individual family members and the family as a group. The listener attempts to identify the antecedents to undesirable behavior (what set it off). New instructions, or new behavior by other family members or a certain family member, replace the antecedents. Desirable responses are agreed upon through a contract with family members. Reinforcements are provided when family members exhibit a desirable response, and consequences are provided if behavior is undesirable. Consistency is critical in both the approval (reinforcements) and disapproval (consequences) of behavior. Positive results, or bonus reinforcements such as family outings or free meals, can be given when behavioral objectives are achieved. Consistency and follow through are essential to success.[64]

Task-Centered Approach

Task-centered methods of treatment seem to merge well with crisis intervention theory and practice, with research indicating that these methods are effective with a broad range of clients. Uncontrolled studies on the effectiveness have been conducted in medical, family, child guidance, psychiatric, school, corrections, and public-welfare settings. Controlled studies in a school system and a psychiatric clinic in southside Chicago rendered very positive results, as did a suicide prevention study and group treatment of delinquent youth.[65] Contracting, task planning, incentives, and homework assignments, which keep families practicing communication and problem-solving tasks between meetings with the crisis worker, are effective in moving the family toward independence and nonabusive behaviors.

The Family Treatment Approach

In conventional family treatment, therapists permit situations to develop which demonstrate how the family interacts and functions. The therapist then tries to engage the most influential members to assure their active involvement in ongoing treatment. Just as in crisis intervention, active listening comes first.

As with crisis intervention the major focus is on the family system rather than one individual. In no way, however, does this prevent the therapist from being aware of assigned family roles ("he is the mentally ill one"), scapegoating ("he is the cause of our problems"), or triangulation ("detouring" of parental problems through the child) within the family.

Family secrets, myths, enmeshment, dyads, triads, and schisms give clues to why the family has become so dysfunctional and what was brewing underneath the surface before the crisis-precipitating event.[66]

Family treatment is inseparable from crisis intervention, and, in addition to being more cost effective for most children and families, family preservation is more desirable than separation.

The Eclectic Team Approach

In an eclectic team approach, team members use their varied knowledge and expertise to assess and manage the presenting crisis. Using their different perspectives, team members work with the family during the initial crisis response, developing a brief treatment plan with specific strategies to foster crisis resolution and healthy family functioning. If only one team member establishes direct contact with the family in crisis, that member consults with other members to ensure that assessment, treatment planning, and treatment techniques incorporate the full team's knowledge and experience.

Interdisciplinary teams, composed of individuals who are eclectic in their training and perspectives, bring a plethora of possible resources and resolutions to any crisis situation. The team's varied perspectives, in conjunction with the clients' innate resources or strengths, are powerful forces that support the clients in steadily lifting themselves out of the crisis. Note that the intervention team strives to not do the work "for" the clients. Instead, the eclectic knowledge is shared with the clients, enabling them to choose problem-solving strategies that restore their sense of well-being and ability to cope.

Eclecticism allows crisis workers to determine which theoretical approach, or combination of approaches, fits the crisis situation best. For instance, the task-centered approach draws from behavioral, communications, problem-solving, and family-therapy models, and assigns "homework" to clients. On the other hand, the cognitive behavioral approach is particularly effective in changing behavior of children and is one of the major theories for work with adults as well.[67] Cognitive theory encourages clients to think through problems and to plan solutions thoughtfully, believing that "emotions, motives, goals, and behavior are conscious phenomena that are usually the consequences of thought."[68]

Other approaches are considered, as well, by the eclectic team. For example, the family-treatment approach focuses on failures of role performance as a parent or spouse, and considers role confusion and role reversal to be present in sexual and physical child abuse cases.[69]

Transactional analysis was founded on the belief that people have the power to think, act, and make positive changes, allowing them to feel OK about themselves and others.[70] Systems theory is akin to ecological and family-centered approaches in that it is concerned about the individual and family in the social environment.[71] Existentialism emphasizes the uniqueness of each client and each situation and allows for openness, empathy, and

honest-but-respectful feedback to clients. Existentialists use "provocative contact" in assertively provoking "hard-to-reach" clients toward wanting change in their lives. This offers clients an opportunity to at least consider the use of behavior modification in making specific behavior or symptom changes.[72]

Gestalt theory does not hypothesize about unobservable systems in the client's life, but may ask the client to reenact his or her perceptions of them.[73] Gestaltists look for patterns or descriptions of interactions, which are not working, as opposed to diagnoses or labels. Similarly, client-centered theory is opposed to diagnosing and labeling, believing that families are capable of knowing and shaping what is best for them.[74]

TECHNIQUES

Special treatment techniques such as humor, generalization, self-disclosure, storytelling, limit-setting, and instillation of hope are effective in crisis intervention. By understanding client resistance, treatment outcomes are further enhanced.

Use of Humor

It is imperative for crisis workers to set aside time for client social activities and fun. Many clients have never had fun. Good professional role models demonstrate a fun-loving sense of humor from time to time.

It is also helpful for crisis workers to respond to their own mistakes with humor. When a verbal or tactical error is made in front of clients, crisis workers need to demonstrate their comfort in laughing at themselves. This helps clients relax and realize that professionals are not perfect and that they may be able to laugh at their own mistakes someday, too. Words of caution are warranted here, however. Some clients are prone to concrete interpretation of humor. In other words, if professionals laugh at themselves or encourage clients to, these clients may feel emotionally degraded. Some clients are ultrasensitive to teasing and require months of addressing past trauma or verbal abuse before they can understand the subtleties of humor.

Generalization

Generalization is another good technique to use with clients in crisis. Saying "we all get angry and don't know how to express it sometimes" is more effective than implying that clients get angry and professionals never do.

Self-Disclosure and Storytelling

Clients need positive role models, but they are relieved to know that professionals are human and sometimes struggle with emotions. The caution here is for the crisis worker to focus on the clients' needs, rather than to vent personal frustrations. To tell a story or two on how the crisis worker or someone else overcame similar problems, however, may be helpful to clients. Crisis workers can test whether self-disclosure is appropriate by honestly questioning, "am I doing this for my benefit or is it for the clients' benefit?"

Setting Limits

All models of crisis intervention emphasize respect for the clients' culture and value systems. Every model also emphasizes the importance of listening closely (for hours) to what the clients are saying. This helps establish rapport but, more importantly, determines what the family is motivated to do. It respects the family's wishes rather than imposing the crisis worker's wishes or needs on the family.

In respecting and being accepting of clients, but not their inappropriate behavior, it may be necessary to say specifically that child abuse and neglect are never acceptable. Many clients need that directive because proper family values were not instilled during their childhoods. Certain clients misinterpret crisis worker acceptance of them as full agreement with their abusive actions. It may be necessary to state frequently that child maltreatment is never an acceptable behavior. If not clarified, clients may assume that the crisis worker approves of such behavior. When encouraging clients to discontinue corporal punishment, for example, it is best to give specific instructions on use of "timeout" for young children, choices and natural consequences for older children, and the need for parents to learn active parenting skills.

Instilling Hope

A crisis worker's belief in self, personal enthusiasm, and ability to instill hope are critical variables in crisis work. If the family senses that a crisis worker believes positive resolution to the crisis is possible, then family members begin to feel confident in their ability to bring about change.

Imparting hope requires crisis workers and clients to search for times in the past when the clients almost succeeded, or did succeed, in finding solutions to similar crises. Likewise, when clients are encouraged to try a new approach, rather than being blamed for failure, hope springs forth. Words such as "when" and "will" should be used rather than "if" or "maybe" when discussing plans.

When crisis workers keep their promises, clients begin to trust and to believe in change. When clients and professionals form a positive "team" that builds on client strengths, change occurs.

Working Through Resistance

By objectively, nonjudgmentally, and respectfully focusing on family strengths and the immediate crisis, crisis workers can minimize client resistance during early intervention. For example, the crisis worker should state the allegations of child maltreatment and ask the family to clarify any discrepancies. Conveying hope that the allegations can be worked through if the family cooperates is effective in moving the family toward desired change. Family members need to know what they are expected to do, what consequences they are facing, and what services they will receive if they cooperate.

Crisis workers must be careful how they use their professional authority. If authority is misused, parents may experience a double message: Parents should not misuse power with their children, but professionals may misuse power with parents. Such double messages create confusion and resentment. If crisis workers expect clients to be effective parents, then they need to be role models of behavior for the parents. Anything less is likely to create new crises, further weakening the family's level of functioning.

In periods of crisis or disorganization, people may feel more inadequate, alienated, or needy, thereby causing them to take on facades of adequacy, arrogance, or dependency. They may withdraw or they may attack, according to what they perceive as necessary for survival. They may act as if they need no help, even when they need it desperately. Whatever the clients' facade, crisis workers must remember that families in crisis crave respect, care, and compassion. They want to regain some semblance of security and stability.

Often, CPS crisis workers complain that the "nonoffending parent" in sexual abuse cases is passive or defensive and refuses to become involved in family treatment. Instead, crisis workers need to evaluate whether the nonoffending parent has always been defensive or passive. If it is new behavior, then the nonoffending parent is merely frightened and afraid the family will be destroyed. Such fears can be honestly recognized by the crisis worker. If the defensiveness is typical behavior, the nonoffending parent will need to observe positive role

modeling, have total honesty from crisis workers, and receive training on how to respond more openly. In the meantime, crisis workers need to realize that an accusation of abuse, the consequent investigation, and an influx of various strangers into the home would make anyone defensive.

By assessing the reasons for clients' recalcitrant behavior, crisis workers can then address the clients' needs for answers or information. They may have many remaining questions about the intervention. For example:

- What further consequences may they expect?
- What happens next?
- What is expected of the family and its members?
- Is the crisis worker a nonjudgmental, credible, honest, and respectful professional?
- What resources can the crisis worker and community offer that can help the family?
- Will the crisis worker listen to and respond to family needs?
- Does the crisis worker see any strengths in the family?
- Is the crisis worker implying that solutions to the crisis are available?
- Is there hope for the future?

Rather than believing that clients are resistant, do not want to change, are denying their problems, or are being deceitful, crisis workers need to believe clients when they express a desire to reach a solution.[75] When clients seem "resistant," it is best to assume that they are merely frightened and hesitant about trying new behaviors or the unfamiliar. They need crisis workers to be patient and listen to how they are feeling and what they suggest for relieving the crisis. If crisis workers convey that clients are the experts on what they want, and if professionals are honest with themselves about what they are feeling, then they will give clients room to make the changes that they need.

For instance, a nonoffending parent in a child sexual abuse case may be fearful of losing her identity as a member of an intact family; her identity as wife of a certain man; her identity as part of a neighborhood or a church; her identity as a member of a respected family; her identity as part of a household which had a good income but must now accept welfare benefits. A skillful crisis worker must be prepared to explore all of these possibilities with the parent, rather than proposing "quick" solutions, such as divorce.

If there is such a thing as resistance to change, some of the causes or sources may be:

- uncertainty about change or fear of failure;
- fear of loss of the familiar;
- lack of confidence in the crisis worker;
- lack of participation in developing crisis resolution goals;

- inability to see change as a viable alternative;
- inappropriate timing on the part of the crisis worker;
- disruption of important, existing family or social relationships; and
- belief that change equals criticism.[76]

Some interviewing techniques which can be used to work through client resistance include:

- active listening and reflection;
- universalizing (normalizing);
- partialization (breaking into several smaller issues) of problems, when the client presents numerous issues;
- ventilation of feelings (with closure before the interview ends);
- summarization of client feelings after extended listening;
- acceptance of the client, but not the client's abusive or neglectful behaviors;
- logical, not rambling and disorganized, discussion;
- education or information about crisis intervention, forthcoming events, community resources, etc.;
- setting boundaries and limits on behaviors and contracting on acceptable alternatives;
- concrete services such as housing, homemaker services, and respite care;
- firm, but kind, confrontation regarding inconsistencies in the clients' statements or behaviors;
- reframing client statements or behaviors to find the positive aspects; and
- joining client resistance by saying "why should you change?" *The crisis worker should* ***not*** *say this regarding acts of abuse or neglect or any criminal behaviors.*[77]

Crisis workers that maintain nonjudgmental attitudes, family involvement, and no preconceived notions about a family's motivation have found that almost all families are open to change for the better. A well-timed, quick response reinforces solutions to a crisis in a limited period of time.

Solution-focused crisis workers are optimistic about substance-abusing, ghetto-residing, chronically disorganized, and even criminally involved families. This means that they do not box families in; they do not categorize or reject them based on their past behavior. Instead, a new, more effective beginning is sought. Many of these families welcome the opportunity to adapt in more socially acceptable ways. They thought no one would ever give them the hope that they could change.

This is not to say that crisis workers should naively proceed as if they see no drug dealing, prostitution, theft, sexual abuse, child abuse or neglect, or spouse abuse in these families. It is rather a matter of being honest but not condescending, being a role model but not acting superior, being a bearer of hope but not bringing false hope, and being a trustworthy person even if family members are not.

Power struggles accomplish nothing of value in crisis intervention. The least cooperative families may become the most receptive to positive change within a few days, particularly if professionals accept them and help them find *their* strengths and *their* solutions to the crisis. Professional commitment and positive attitude toward short-term resolution of a crisis are sensed and appreciated by clients. They have a sense of self-worth when crisis workers ask: "What do you want to happen?" "What do you want to change?" "What do you want to do?" and similar questions that respect clients' competence.

If crisis workers are respectful of culture and empathetic with the predicament in which families find themselves, new horizons may start to open up. For many families, crisis workers will only have time to help them stabilize, but can help them contact other therapists and agencies where client culture is honored.[78] Ultimately, crisis workers who are effective listeners are so responsive to clients' needs that there is no reason for clients to resist. This, however, takes great patience and a willingness to meet clients' needs rather than crisis workers' needs.

SUMMARY

When in crisis, families' feeling, thinking, and behavioral patterns are more likely to be positively impacted by a highly focused, eclectic team approach that uses a multitude of coordinated, community resources. Use of task-centered, cognitive behavioral approaches, along with a flexible repertoire of other theoretical approaches and techniques, allows professionals to tailor interventions according to a family's chosen goals.

When clients choose their own goals, they do not resist making changes. For instance, if clients want interventions to end and choose ending the interventions as a goal, they may not resist modifying their illegal behavior. Professionals use special treatment techniques, such as instillation of hope, generalization, and humor to elicit additional cooperation from one or more family members.

UNDERSTANDING SPECIAL FAMILY SITUATIONS

INTRODUCTION

Because of specific stressors, assessment of a few special family situations deserves discussion. Crisis workers need to be especially sensitive to how child maltreatment may occur in response to divorce, stepfamily, single-parent family, drug dependent and drug related, spouse abuse, mental illness, dual-diagnosed, and poverty-induced crises.

MARITAL CONFLICT

Custody disputes and unresolved issues from divorce, along with the children's confusion and desire for both parents to be with them, set the stage for children to be used as pawns.[79] Consequently, the crisis worker must be diligent in monitoring his or her feelings and in neither identifying with nor rejecting any family member. This is particularly true for one with similar experiences in his or her own past or a current marital conflict. The same holds true for a crisis worker who was in a divorced family as a child.

Marital separation is said to be more painful than the death of a spouse. The grieving process, related to the separation and loss, needs to be encouraged by crisis workers. Social involvement with other people is of benefit after separation in order to move outside one's sense of loss and feeling of poor self-worth.[80]

Occasionally, bitter ex-spouses may be vindictive or, in their wish to find flaws in the ex-mate, may believe that sexual or physical abuse of a child is occurring, when it is not. On the other hand, crisis workers must consider whether abuse has occurred, even when investigative workers have indicated that accusations are unfounded. In the face of rejection and unmet emotional needs, a parent may sexually abuse a child.[81] The crisis worker can get the most objective information from children by listening and observing family interactions over extended periods of time. Contrary to the predicament of the investigative worker who is often pushed for time, the CPS crisis worker is in a perfect position to observe attentively for hours. Children's behaviors and their parent's attitudes and behaviors can give critical information for evaluation by the crisis worker. Objective but thorough exploration of abusive allegations can be reassuring to the accuser, the accused, and the child.

STEP-PARENTING CONFLICT

In many instances, two families are able to merge quite successfully; other families find the merger more difficult. Some families are prone to have conflicts around who has the right to discipline. Lack of agreement may result in conflict between the adults and, possibly, displacement of anger throughout the family. Youth in these families may learn to be manipulative if adults cannot come to a consistent, reasonable, mutually agreeable disciplinary approach.

Crisis workers must assess what may be happening in the family. To establish more positive alliances among family members, crisis workers should listen and observe for long time periods, while maintaining objectivity. For instance, is a child acting out as a response to feeling rejected by his step-parent? Children who feel unwanted are likely to act out.

Discipline of the children may require special attention and suggestions by the crisis worker.[82] In fact, this is a good way to gain immediate credibility regarding professional knowledge, while providing emotional relief for parent(s) and children who are feeling desperate because of ineffective disciplinary techniques. For instance, a step-parent may feel unable to control a child and, therefore, ready to give up. The crisis worker can say, "What if we work together to find effective ways to discipline, so you can be the parent you want to be?"

In addition, children in stepfamilies may blame themselves for the continuing arguments between their birth parents. Both parents may also attempt to use the children as pawns or messengers. Some children may perceive that a parent is more loving and solicitous with step-siblings than with them. If so, every effort must be made to apply the same rules, rewards, and responsibilities with all the children.

Another area of conflict arises when each side of the step-family feels its traditions or ways of doing things are best. There may be arguments over what is "right" or "wrong." The family may need to realize that there are many different ways to accomplish desirable ends within a family. Respect for each other's feelings or traditions is more desirable than rigid adherence to one tradition.

Role strain in step-parents may also be evident, especially when there is lack of clarity in spousal expectations. Step-parents need to be encouraged not to avoid conflict; but, instead, to seek social support, learn to ventilate but manage their emotions, and realize that many role stresses are time limited.[83] Rather than withdrawing from the family, it is better for the adults to ventilate feelings with each other and get their roles clarified.

UNPREPARED FOR PARENTHOOD

Generally, the poorest of the poor are single-parent families. As if poverty were not enough, many single parents are adolescents who have little knowledge of children's needs and have unrealistic expectations of their children.[84] They do not understand why babies fret or cry. They need help in providing nutrition, preventive health care, emotional nurturance, and discipline. They need to understand their own human growth and development, as well as that of their child. Mistakenly, many had thought that a child would meet their needs for love and admiration. They felt that a child would be all theirs, something that they could control, something that would help them gain status, never realizing that the child would interfere with dating and socializing.

The crisis worker must help correct these mistaken dreams while improving the single mother's self-esteem, encouraging further education, seeking quality and affordable day care and, very likely, mediating arguments between the teen mother and her parents regarding "ownership" and discipline of the child. Realistic goals and expectations for three generations require considerable communication and negotiation. Usually, involvement of the grandparents is desirable, even if only to keep them from undermining the single mother's realistic goals.

Another problem the young single mother has is that of choosing boyfriends. This is especially true for the young woman who has an unresolved history of child sex abuse or other familial violence. Many boyfriends, who are not bonded to the single mother's child, misuse the child. The mother needs encouragement to select boyfriends who are drug-free, nonviolent, and have appropriate sexual boundaries. Improved self-esteem and assertiveness are helpful in the mother's attempt to set boundaries.

SUBSTANCE ABUSE

Alcohol and many other drugs are disinhibitors, making it easier for users to lose control of impulses, thereby engaging in physical, sexual, or emotional abuse. Likewise, persons who have been victimized may use alcohol to help them express anger, sedatives to mask the emotional pain, or any other drugs for self-medication and escape from misery.

When alcohol or other drugs are a part of a family's problems, an evaluation is needed regarding the efficacy of outpatient substance abuse treatment. For instance, one study found once-weekly therapy to be ineffective with cocaine addicts.[85] Some clients will even need detoxification, but these decisions require crisis workers to have the skills for evaluating addictions.

At least one member of a crisis intervention team, or a consultant, should have expertise in the evaluation and treatment of substance abuse. Drug screens are now used extensively in both outpatient and inpatient treatment settings because they keep clients from "fooling" themselves and others. Whenever substances are being used, yet denied, random drug screens should be considered.

Alcoholics Anonymous, Alanon, Alateen, Narcotics Anonymous, and other such support groups are critical parts of intervention and treatment. However, social stresses and internal needs require special attention from crisis workers. It is not easy, for instance, for an adult who is depressed and anxiety-ridden to stop self-medicating with substances. Similarly, it is difficult for some workers to understand that the "substance" becomes the central focus in the life of the addict, making the "substance," not the family, the top priority.

Crisis workers can expect persons who are in recovery to use substances from time to time.[86] Some crisis workers feel rejected and disappointed when this occurs, in turn rejecting the addicted client. Learning that relapse is part of recovery is essential for successful assessment and treatment.

Drug dependency should not be the only concern. Dealing drugs is a major business, putting many youth at risk of seeing drug-related violence on "bad deals." Since prostitution to support a drug habit is interwoven into the drug using, drug-dealing scene, children are at risk of seeing inappropriate sexual behavior and of being used as sex objects. To work with these families requires street-wise training for crisis workers and specific guidelines for clinical intervention.[87] Crisis workers need to help the youth in these families find recreational, educational, social, and spiritual activities that move them toward a drug-free, productive life. The spiritual activities must be voluntary and agreeable with the parents, as well as the youth.

SPOUSE ABUSE

As spouse abuse is increasingly being identified in families who abuse and neglect their children, and has great emotional impact on the children, crisis workers need to screen for domestic violence, possibly using an inventory. Crisis workers must be aware of possible indicators of spousal abuse and skillful in determining the level of risk that a batterer may present to family members. This must be done in a way that does not escalate the risk of violence to others and children. Mothers and children are often fearful of disclosing abuse in the presence of the abuser for fear of retaliation.[88] Likewise, confronting an abuser with allegations and statements from family members will increase the risk of harm.

It is important to recognize that battering is not only about violent assault but also involves a host of actions in which the batterer establishes increasing levels of power and control over the victim. It must be understood that in many, if not most, circumstances battered women do not feel that they can "just leave." Their concerns are supported by some data that indicate that the potential for lethality increases when a woman tries to leave. Understanding the true level of danger is an essential part of intervention. Access to weapons, substance abuse, mental illness, threats of homicide or suicide, and the patterns and the severity of the abuse itself are all key considerations.

The needs of children in violent households are a primary consideration, and assessment should examine the effects of violence on them. Children who witness battering may exhibit a variety of symptomatic behaviors from aggression to fearfulness, depending upon the age and sex of the child, the presence of child abuse and neglect, and other family experiences and characteristics.

Crisis response considerations must focus on safety first—for both the mother and her children. A successful plan for their safety should be developed jointly with the mother and should consider her concerns, her experiences, and her resources. Treatment should likewise support ongoing safety for mother and children and may involve the use of shelter services, legal intervention and counseling services, as well as batterers treatment programs for perpetrators.

Recent innovative work has demonstrated that intervention can achieve safety for mothers and children without placing the children away from their mothers. Additional support services should include safe-visitation arrangements, advocacy, and assistance in ensuring adequate housing, health care, and employment.

MENTAL ILLNESS

Crisis workers must be aware that many families have members who have a variety of personality and other mental disorders.[89] It is documented that neglectful mothers likely have character disorders and/or depression. Some may even be psychotic.[90]

In practice, it is better for crisis workers to stay nonjudgmental and unbiased toward these family members because some have been scapegoated or given the role of the "problem" family member.[91] Some parents may have adapted to past stress by becoming homeless, mentally ill, self-medicated with substances, or by refusing to take prescribed antipsychotic medications. Whatever the past, the openminded crisis worker assumes nothing and instead observes the family's present interactional patterns and miscommunication. Sometimes, the person who is most in contact with reality is the designated mentally ill member. In other families, the current crisis can only be resolved through psychiatric hospitalization, an adjustment of medications, or new solutions within the family. If a mentally ill parent must be hospitalized, care for the children could, perhaps, be provided by homemakers, relatives, or others within the child's home so that out-of-home care is unnecessary.

Recently, the prevalence of childhood sexual victims among sufferers of various psychiatric disorders has become evident. Borderline and dissociative identity disorders are good examples.[92] It behooves the crisis worker to study the literature on both of these disorders, as such enlightenment could reduce frustration in working with these clients.

Some clients with borderline personality disorder may appear withdrawn and dependent; others may seem irresponsible, remorseless, overly seductive, envious, self-centered, unstable, or resistive. Still others may seem very manipulative, rigid, jealous, blaming, argumentative, perfectionistic, self-defeating, immature, impulsive, sadistic, or suspicious.[93] Clear boundaries and expectations are required with such clients who get more demanding when roles are nebulous. It is the intervener's task to try to establish a fresh start with such a client through honesty, openness, positive role modeling, and gentle confrontation.

Clients with dissociative identity disorder have two or more distinct personality states which take control of the clients' behavior. There is an inability to recall important information. Crisis workers may feel confused or perplexed by the changing attitudes or personalities of such a client who requires long-term psychotherapy by a highly trained professional.

These clients need long-term treatment, but it all starts with a credible crisis worker who is not blaming, accusing, or self-righteous, and who never uses threatening tactics. Some of the most appreciative and responsive clients are those who seem most impossible at the first meeting.

DUAL DIAGNOSES

Crisis workers must have skills for assessing individuals who have dual diagnoses such as mental illness and alcoholism or other drug addictions.[94] They must also be cognizant of other forms of co-morbidity: mental retardation and addiction; mental illness and mental retardation; and sexual addiction and drug addiction.

There is debate among professionals about which problem needs to be assessed and treated first. Generally, crisis workers must think about assessing and treating the total person and the total family. Dual assessment and treatment plans for both diagnoses are usually required. There are some clients who, early in crisis intervention, must be detoxified prior to attempting treatment. However, drug usage and other problems, such as child sexual abuse, are so closely connected that assessing and treating one without assessing and treating the other poses a continuing risk to the family.

POVERTY

As the number of children living in poverty increases, more children are at risk of harm from the repetitive trauma of poverty. These children represent at least one-fifth of all children in this country; and, with the decreasing availability of low-cost housing and the increasing cuts in public assistance, more families can be expected to suffer from the chronic stress of poverty until new opportunities for the poor are developed.

Many families living in poverty have lost hope and no longer have the energy to overcome any additional sources of stress. Withdrawal or sudden outbursts may seem to be their only coping responses. Concrete services, instillation of realistic hope, and prospects of job training or jobs can provide a boost of energy to such clients. Initially, the crisis worker may need to go with the clients to seek health care, food, and clothing. As progress is made, however, the clients can be encouraged to assume more responsibility for completing tasks alone. They need to hear encouragement and praise from the worker. If they are to maintain their gains, an ongoing case manager may be needed.

SUMMARY

Professional crisis workers do not pre-judge their clients, but can better understand families' behaviors by studying the stresses created by certain conditions. Marital conflicts can create a multitude of fears and worries in adults and children. Step-parenting requires more negotiation than parenting and works best when the step-parents agree to discipline all the children mutually.

To offer the best intervention to abusive or neglectful families, crisis workers need special knowledge regarding teen parenting and single parenthood, chemical dependency, dual diagnoses, spouse abuse, the effects of mental illness, and poverty. Enlightened crisis workers recognize that sexually transmitted diseases, including HIV/AIDS, may further complicate the lives of their CPS families. Nevertheless, by concentrating on a family's strengths, intervention goals can be attained in a few weeks.

TERMINATION AND FOLLOW-UP SERVICES

INTRODUCTION

When crisis workers are able to convey a positive attitude about termination and follow-up, the family is left with a sense of accomplishment and self-sufficiency. From the beginning of crisis intervention, time limits, problem-solving, and empowerment toward independence are used to demonstrate confidence in clients' ability to overcome their predicament. Review and evaluation of their progress can enhance their self-esteem and prepare them to cope more adequately with future crises.

ESTABLISH TIME LIMITS FROM THE BEGINNING

The plan in every crisis intervention case is to limit the length of intervention, usually to between 4 and 12 weeks. (The current trend appears to be in the direction of the 4-week period, particularly when follow-up services are available in the community.) The family is apprised from the onset regarding the maximum length of intervention and is reminded from time to time. Time limits help families focus and move at a lively pace in making changes.

TEACH PROBLEM-SOLVING

Rather than "doing it for them," crisis workers must help families seek and use new approaches to solving their problems. Families learn coping skills to help them avoid future crises.

ENCOURAGE INDEPENDENCE

Time-limited, problem-solving approaches reduce dependence on the crisis worker, but so can suggestions that family members identify and implement their own goals and action steps. Crisis workers do not rescue. They empower clients to care for themselves. As clients gain access to various coordinated community services, they are less likely to remain dependent on the crisis worker.

Crisis workers teach assertiveness and empowerment to victims and abusers alike, allowing them to be in control of themselves and not frightened, helpless, overly aggressive, or dependent. These strategies help build toward the termination of the crisis services.

REVIEW PROGRESS

During termination with a family, reviewing with families where they started and what they have accomplished reinforces their readiness for termination of the intervention. The crisis worker engages the family in a celebration which focuses on:

- the family's ability to be an independent, adequately functioning system;
- tasks accomplished;

- new family coping patterns; and
- past and future use of resources.

ESTABLISH A PLAN FOR FOLLOW-UP

Families vary in their need for follow-up services. Many require ongoing CPS case management to ensure the continued safety of the children. Additionally, some require referral to specialized, ongoing treatment programs or resources. All families, however, need to know that they can contact the crisis worker, if necessary, and that the crisis worker will be contacting them at a specific time in the future. A call to "see how the family is doing" reinforces progress.

EVALUATE OUTCOMES

Outcome evaluations help crisis workers determine their effectiveness. Some of the critical outcome questions are:

- What does the family perceive as the outcome of the intervention?
- What were the specific changes in the clients' "feeling," "thinking," and "doing?"
- Were short-term goals largely accomplished?
- Are gains being maintained 6 months later?
- Is there recurrence of the same or similar crises?
- Do the children and parents appear to be safe and appropriately managing anger?[95]

During the initial contact, families need to understand that crisis interventions are short lived; they need to know the absolute maximum length of intervention that can be offered. Independence is encouraged by teaching families how to solve the current, as well as any future, crisis. A review of the desired outcomes and a formalized plan for follow-up help create a positive termination.

THE CRISIS INTERVENTION WORKER

INTRODUCTION

Crises can occur at any point in the CPS process. Therefore, crisis intervention skills are necessary for all CPS staff. Equally important is awareness of several issues which can affect the interviewers' abilities to remain objective. Interviewers' vulnerability and safety, psychological state and feelings, susceptibility to burn-out, and need for supervision and training are issues that are addressed in this section.

VULNERABILITY AND SAFETY

Vulnerability and safety are experienced on both an emotional and physical level. Crisis workers care about their clients, which makes them vulnerable to personal disappointments. Being over emotionally involved can invite physically harm because of client jealousy or feelings of rejection. This means that an objective, nonjudgmental attitude is a necessary part of worker safety. The following are techniques which can increase the likelihood of interviewer safety. Interviewers should:

- identify themselves, their agency, their reason for intervention, and their desire to help;
- listen actively and show acceptance when it is appropriate;
- face client(s) at all times;
- maintain eye contact and be patient;
- encourage open expression of feelings;
- respond with "tell me more" or head nods;
- set verbal limits softly, giving "hope," if that is realistic;
- avoid giving false assurances;
- search for boundaries for anger (ask how long the client has felt angry and how many people are involved);
- determine if anything has helped decrease the anger;
- paraphrase or reflect what the client seems to be saying and ask if that is correct;
- compliment something positive that is said or is important to the client(s);
- thank the client for trying to help the crisis worker understand;
- make sure all parties have clear access to doorways;

- if sitting, lean forward to show interest; but be careful not to "crowd" the client;
- after listening, make positive statements such as, "I know you want to do what's best and so do I";
- generalize by saying, "Life is not always easy or fair, but we can find ways to deal with this"; and
- use distraction to decrease tension such as, "That's a beautiful painting on the wall. When did you get it?"

In some situations, where anger is escalating, it may be best to say, "I want to help so much, but it may take several good minds to work on this." Then the worker should call for other team members or ask to be excused to go get them. If at all possible, the crisis worker should try to show no panic, knowing that most clients are looking for role models who are in control of their own emotions but are not trying to "control" the client.

In situations where there is danger of physical harm or doubt about the crisis worker's safety, more than one crisis worker should go to the home. Hopefully, at least one member of the team is familiar with and already accepted in the neighborhood. This decreases the likelihood of harm. It is also appropriate to ask clients to put away weapons.

Law enforcement escorts may be needed in some CPS situations. Use of law enforcement escorts is appropriate when the risk of danger is unusually high, such as a family's past history of domestic violence, an isolated or violent geographic setting, mention of firearms in the report, or information on mental illness, drug usage, drug dealing, or other volatile situations. When responding after regular working hours or to a repeat complaint against a family, a second caseworker may be needed.[96]

Ultimately, it becomes a matter of experience, what feels safe, and the philosophy of a particular team. No crisis worker, however, should be forced to deal with a family with whom the worker feels overwhelmingly unsafe. As Markowitz states, most workers are able to overcome their fears as they become familiar with neighborhoods: "Therapists who do home-based work become inured to the feeling of danger after working for a short time in a crime-ridden area."[97]

PSYCHOLOGICAL STATE AND FEELINGS

When a crisis occurs, the crisis worker must evaluate his or her own emotional state as well as the psychological state and feelings of the clients. Lack of honesty about one's own emotional and physical state can interfere with the establishment of trust. For example, a worker who had physical pain and slight emotional problems was working with a sensitive client who later said, "I thought you were fed up with me." She had misinterpreted the worker's personal difficulties.

Particularly, any feelings of dislike or resentment toward clients require discussion with a supervisor or peer. Sometimes workers begin to accuse, blame, displace anger, or overly identify with clients. Every professional needs to struggle with maintaining objectivity. For instance, previous life traumas at home or work, or current conflicts with relatives or employers, can affect how the worker views clients. If crisis workers find they are concentrating on client weaknesses, rather than strengths, then it is time for consultation.

PREVENTING BURN-OUT

Working with families who abuse or neglect their children can be personally exhausting. Crisis workers can become frustrated with uncooperative community resources just as they can become frustrated with the family. If a family's problems remind crisis workers of their lives, they can become overly attached or develop an aversion

to working with them. There may even be times when crisis workers fear for their lives or the lives of family members.

To ventilate feelings and find the positive in every case, the crisis worker needs debriefings with the supervisor and team. Such debriefings offer the crisis worker the opportunity to think through, in a supportive environment, what really transpired during crisis intervention. Sharing the progress and regression of a case allows the crisis worker to discharge feelings on both personal and professional levels and to learn new ideas and techniques which prepare the crisis worker for future cases. It provides a stabilizing, reality-oriented forum for reminding the crisis worker that unrealistic expectations bring disappointment and burn-out. Realistic expectations for families lead to stabilization and feelings of satisfaction for them and for the crisis intervention team.

SUPERVISION

Because families and their crises are so varied, skillful supervision is critical to the success of the crisis intervention whether it is a part of Child Protective Services, a family preservation program, or other crisis service. The crisis worker should be able to contact the supervisor at any time, 24 hours a day, 7 days a week. Sufficient administrative backup should be available to cover whenever the supervisor is absent.

Also, the supervisor should be notified immediately if there is a threat of harm to a child or other family member or to the crisis worker. This includes any suicidal threats made within the family. The supervisor also should be contacted when the family is resisting a meeting or bluntly refusing to meet or when it appears that a child needs to be placed out of the home.

Most other concerns can be discussed during regularly scheduled supervisory meetings, peer group supervision, or ongoing staff training. These might include the following:

- difficulty focusing on a family's goals;
- feeling tired, bogged down, or burned out;
- dislike of, or an aversion toward, working with a family;
- feeling disliked by a family;
- not knowing how to deal with a family's anger;
- over-investment in or wanting to "hang on to" a family, even though it is time for termination;
- realizing that personal feelings and past experiences are similar to those of the family;
- feeling that divorce or out-of-home placement is best for the family;
- thinking or worrying constantly about a family;
- finding it difficult to listen actively to the family;

- disagreeing with a family about the goals of intervention; and
- wanting "success," i.e., reunification or keeping the family together, even though it is detrimental to the children.

Supervisors must maintain open and honest lines of communication, encouraging crisis workers to find the positive in situations and to set goals accordingly, much as workers do with families. For additional information on supervision, the reader is referred to another manual in this User Manual Series entitled, *Supervising Child Protective Services Caseworkers.*[98]

TRAINING REQUIREMENTS

The success or failure of crisis intervention depends primarily on the expertise of crisis workers in a variety of areas. For example, organization, planning, diplomatic assertiveness, and flexibility are critical practice skills.[99] The ability to work with other service providers to cut through agency and system barriers is a very important skill. Ultimately, crisis workers need training which helps them to understand abuse and neglect through a child's eyes, while they access services to address the child's pain and promote family healing. Training and staffing must address the broad cultural diversity of families that CPS and other crisis teams serve.

The Behavioral Sciences Institute, Homebuilders' parent organization, has an extensive crisis-intervention training package which illustrates the range of topics involved in specialized training. Topics include: Diffusing dangerous situations, self-defeating and self-enhancing ideas, goal-attainment scaling, family life education, value of concrete services, client values and lifestyles, rational thinking, engaging the clients, confronting clients, family assessment, life skills such as anger management and conversational skills, assertiveness, appropriate expression of positive reinforcement, use of behavioral charts, gathering suicide risk information, use of "I" messages, assigning homework, identification of feelings, the social network and family support system, child management, dealing with lack of progress, problem-solving and negotiation, making referrals, evaluation of services, and when to contact a supervisor.[100] The training requires 2 weeks of pre-service training plus ongoing inservice training.

SUMMARY

During the crisis-intervention process, professionals use specific techniques to assure safety for themselves and all family members. When anger escalates during an interview, the crisis worker may need to be excused to call for another team member. In some volatile or criminally laden situations, law enforcement accompaniment is needed.

Quality individual and group supervision, training, teamwork, and personal respite can assist crisis workers in maintaining objectivity, enthusiasm, and emotional health.

FAMILY-CENTERED CRISIS RESPONSE MODELS

INTRODUCTION

In response to the growing number of children in foster care, the emotional and social disconnectedness or rootlessness of large numbers of these youth, and growing recognition of the value of the family, family-centered or home-based services have developed. Some of the family intervention models that may be available in a particular community are presented in this section. Several of the therapeutic strategies require that the crisis workers receive extensive training before they implement the strategies.

Three examples of successful, family-centered services programs are the Homebuilders crisis intervention model, the FAMILIES, Inc. home-based model, and the Intensive Family Services (IFS) family treatment model.

HOMEBUILDERS

This model assumes that most children who are in imminent danger of removal from their homes can best be served through interventions which keep the family intact.[101] Homebuilders subscribes to the following seven principles:

- **Children Need Families**—The Homebuilders' intervention philosophy emphasizes that one's beginning and ancestry are overwhelmingly important to the development of self-identity. Bonding with parents is critical to the cognitive and emotional development of youth. Behaviorally disordered youth clearly demonstrate their need for consistent family life.

- **The Safety of the Child Comes First**—Through its low case loads, no more than two cases per crisis worker at any time, and training of crisis workers to defuse dangerous situations, Homebuilders designs its program to provide safety for children. Rapid response, within 24 hours, and frequent visits to the home help to curb the escalation of family stress and danger to the child. Parent and crisis worker safety are also important program components.

- **Crises Present Opportunities for Change**—Homebuilders is designed to capitalize on crises, when families are under great stress and looking for new directions because old ways of coping are not working. Cognitive-behavioral approaches, concrete services, a multidisciplinary team, and active listening are used to help stabilize the family. The family determines short-term goals, with crisis workers keeping the family focused on what can be accomplished in a 4-week period. After a relationship is established, most families are open to learning parenting and communication skills, anger management, and more effective coping strategies.

- **Limit the Issues To Be Addressed**—After carefully assessing the stress in the family, Homebuilders concentrates on what the family needs in order to stabilize. Crisis workers focus only on critical issues in the present. For instance, utility or rental payments may need to be made to prevent the family's eviction. Family members may be taught to listen to each other, instead of yelling and accusing. Parents may be assisted in finding job training or mental health counseling. Children may be placed in day-care.

- **Family Members Probably Care About Each Other**—Even though family members argue, abuse, or neglect each other, Homebuilders stresses that most families have strong caring feelings. Because of insecurities and emotional needs, it may appear that individual members are too self-centered to care about others. Their actions may seem to say that there is no caring. However, in-home observation usually indicates that there are caring moments and that family members love each other.

- **Family Members Are Doing The Best They Can**—Whatever the crisis, Homebuilders believes that families are doing the best they know how under the circumstances.

- **The Power for Change Lies Within the Family**—Through an attitude of respect for the family's strengths, Homebuilders empowers family members by helping them determine what they need and how they wish to proceed. Crisis workers become energized, as well, when they realize that families want to change, can set their own goals, and can follow through with their action strategies. Just as all children need encouragement, so do adults who are in a crisis. Encouragement and professional support help families use their strengths for positive change.

FAMILIES, INC.

This model, using Nathan Ackerman and Virginia Satir's family treatment methods, was developed as an alternative to foster care for adolescents. Drawing on family systems theory, it provides home-based services to achieve more accurate family assessments, to model behaviors in the home environment, and to facilitate empowerment of the family.[102] Frequently, it assigns an experienced crisis worker and a new crisis worker to a family, allowing for flexibility in schedules and for planning cases together.[103] It provides intervention for 3 to 7 months. Caseloads vary from 5 to 11 per crisis worker.[104]

Families, Inc., uses a variety of approaches from family systems theory such as genograms, reframing, and structural techniques.[105] Other intervention techniques include assigned homework regarding communication skills, paradox, parent training, fair fighting, and provision of concrete services. These approaches are described below.

- **Genograms**—Genograms are diagrams of the family tree through three generations. These diagrams can become large and complicated in families of many marriages and children, but can be used to pinpoint specific times and types of stress in the family. Repetitive patterns and recent occurrences which led to the crisis may be identified, as well as how various family members relate to each other and to the world outside the family.

- **Reframing**—Individuals and families have thoughts, feelings, symptoms, and behaviors which they or other people perceive as undesirable. Reframing attempts to emphasize the positive aspects of the "undesirable." For instance, a parent who physically harms a child might be positively recognized for wanting the child to behave, thereby opening the door to teach anger control and appropriate discipline. Reframing is used in both paradoxical and nonparadoxical therapies.

- **Structural Techniques**—Much like task-centered techniques, structural family therapists assign tasks for clients to accomplish between sessions.[106] The therapists may try to create new alliances among the family members while also establishing new and different alliances from time to time between therapists and various family members.[107] All this is done in an attempt to create a more functional family. The structural approach is concerned with behavioral and affective themes related to boundaries and role enactment.[108]

- **Communication Homework Assignments**—The past, the present, and the environment affect how one receives and processes information. In families, patterns of communication develop over time. Verbal and non-verbal communication may not be congruent.[109] Families may not know how to get assistance about jobs, housing, controlling anger, or child discipline. Couples may not understand each other's style of communication.[110] Likewise, some authors caution that professionals' and clients' racial or cultural differences may create misunderstandings in communication.[111]

- **Paradox**—Many therapists find it helpful to side with individual and family resistances to change, often requesting or "prescribing" families to engage in the very behavior which therapy is attempting to eliminate.[112] Paradox may be a client's intuitive response as well as planned response. Clients may be encouraged to pretend that they have even more symptoms, such as anxiety and embarrassment, or they may be urged to yell more than usual.

  Before using paradoxical instructions, therapists must study appropriate application of this technique. For instance, one would never "prescribe" hitting or abusing a child, using alcohol or other drugs, or breaking the law![113]

- **Parent Training**—Numerous authors contend that adults who were unloved and uncared for as children may never become nurturing.[114] With parenting education and other interventions, such as role modeling, role playing, and resolution of childhood trauma, they may, however, learn to parent appropriately.

- **Fair Fighting**—Many abusive parents feel frightened and inadequate. Their poor self-esteem is expressed through overly submissive or overly aggressive behaviors. They need to learn appropriate assertiveness, how to negotiate for what they want, how to compromise, or how to persuade without yelling and hitting. Having had poor role models in the past, they must be taught how to fight civilly by clearly expressing their feelings about what is bothering them, by asking for reasonable change, by clearly stating the consequences, and by using "I" messages, such as, "I feel like a child and get scared when I'm not in control."

- **Concrete Services and Coordination of Services**—Typical of good casework services, Families, Inc. crisis workers advocate for their clients to receive more adequate support services.[115] This includes coordination with other community providers to assure quality living conditions and services both during and after the intervention. Concrete services are an important part of the intervention and include arranging for necessities such as food, clothing, housing, health care, and financial assistance. Transportation, day-care, job training, and other services also contribute to the families' success.

INTENSIVE FAMILY SERVICES (IFS)

Relying on family systems theory with less emphasis on concrete services and support services than the two previously described models, this program provides approximately 3 months of service either in an office or home setting.[116] Other community services such as respite services and parent training supplement the work of IFS. Using this model requires crisis workers to maintain a caseload no more than 11 cases. Approaches to treatment include structural, strategic, brief, and communication-based family therapy, as described below.

- **Structural Family Therapy**—Founded by Dr. Salvador Minuchin, structural family therapy aims to establish clear relationships and role boundaries, to develop functional alliances within the family, to normalize the role of the child who functions as a parental surrogate, and to develop tasks which improve family functioning.[117]

- **Strategic Family Therapy**—In strategic family therapy, the therapist assumes control of the treatment and designs an approach to each problem. With complex families, the therapist may involve a co-therapist or a team of consultants to assist in dealing with the multiple family dynamics.[118]

  Strategic therapy calculates the strength of the "anti-change" forces of the family and attempts to work through resistance through indirect means. Sometimes the expression "joining the resistance" is used to reflect how the therapy capitalizes on and exaggerates the resistance or homeostatic behavior as a means to eliminating it.[119]

- **Brief Therapy**—In 1958, Leo Bellak began a 24-hour psychiatric emergency clinic based on psychodynamic therapy, but limited to five therapy sessions.[120] Since that time, many therapists have asserted that brief casework may be more efficient than long-term interventions. Brief therapy practitioners use highly focused, task-oriented approaches and homework assignments to help clients develop their own problem-solving strategies. Written contracts explicitly state the acknowledged problem, the clients' goals, and tasks for alleviation of the problem.[121]

  Some practitioners emphasize the positive in clients' lives, always empowering the clients and constructing questions or statements in such a way that the clients feel there is an imminent solution to their problems.[122]

- **Communication-Based Therapy**—Communication-based therapy is based on the belief that what people perceive within themselves and their environment is more critical than what is real. How clients receive information and how they process it determine its ultimate effect on their functioning.[123] If clients are not responding to communication as the professional expected, then he or she needs to communicate in a different way. Body language, tone of voice, or timing may require change. It is the professional's job to communicate in ways that help clients accomplish their goals.

THE FAMILY CRISIS PROGRAM

In Boston, the Family Crisis Program (FCP) for sexually abused children is based on classic crisis theory and applies a comprehensive approach involving investigative, clinical, judicial, and advocacy agencies.[124] The program assumes that a report of sexual abuse precipitates crisis in the family in which usual coping patterns are overwhelmed. Responding immediately to the family's crisis workers, program staff seek to restore equilibrium and more adaptive coping mechanisms. Families are helped in obtaining emergency social services or in seeking a restraining order against the perpetrator. About three-fourths of the families require treatment beyond crisis intervention.

THE INTERAGENCY SEXUAL ABUSE COUNCIL

Designed to provide crisis intervention during the chaos of incest disclosure, the Riverside Interagency Sexual Abuse Council (RISAC) in California is a joint effort of public social services, mental health, probation, and several other agencies. Self-help groups such as Parents United and Daughters and Sons United, as well as individual, couple, and family therapy, are adjuncts to the crisis intervention. The program is both supportive and confrontive with perpetrators, while encouraging behaviors that minimize family stress. Victims are supported and believed. Nonoffending mothers are confronted if they deny knowledge about the sex abuse. All interventions, however, are compassionately supportive and humanistic.[125]

SUMMARY

In Child Protective Services, family-centered models are most effective for crisis intervention. Three national models of family preservation and two community programs utilize approaches and techniques that can be easily adapted to Child Protective Services crisis cases. Two models draw heavily on concrete and community support services, while another provides approximately 3 months or more of intervention.

SUMMARY

WHEN CRISIS OCCURS

When a crisis occurs in a family, such as a child abuse or neglect report and investigation, family members are more likely to accept intervention from "outsiders." Through focused and coordinated efforts, crisis workers can profoundly strengthen or stabilize families in crisis, helping parents become more nurturing and supportive of their children.

In addition to being well coordinated with other community resources, during and after their time-limited intervention, crisis workers make planned responses to the families. A response to the family is made within 24 to 72 hours. After hours of active listening, the crisis worker encourages the family to choose one to four treatment goals on which to focus for about 4 to 12 weeks, although a few crisis intervention programs continue for 4 to 6 months.

The respectful crisis worker facilitates the family's ability to change what it wants to change, not what the worker wishes it would change. By focusing on a few goals, most families become less frustrated and, thus, safety for the children is assured. The 24-hour, 7-day-per-week availability of the worker is critical to the children's safety.

Using a positive attitude and an eclectic, time-limited, solution-focused approach to treatment, crisis workers are wise to provide concrete services as well as counseling. Prior to and during the termination phase of treatment, family members are encouraged to "celebrate" or enjoy their accomplishments. Throughout the process, a family focus is maintained.

Crisis workers do not burn out when they are well trained, discuss cases with their supervisor and peers, and feel comfortable in being honest about their personal feelings during supervision. Family preservation programs report 70 to 90 percent success in preventing out-of-home placements while also keeping children safe. By concentrating on the total family, rather than "rescuing" children, crisis workers' respectful approach enables families to stay together.

ANTICIPATING CRISES AND PLANNING PROACTIVELY

Instead of waiting for child abuse and neglect crises to occur, every community should work toward an integration of services which are responsive to individual, family, neighborhood, and community needs.

Health, education, law enforcement, and social service agencies should strive to overcome fragmented programs by offering comprehensive services that provide early intervention, prevention, and family-oriented programs and allow for collaborative teamwork.

Planning together as a community allows for the development of a continuum of care that addresses the holistic needs of families and clearly assigns roles to each participating professional and organization, keeps children safe, improves family functioning and, where possible, keeps families together. Thereby, crisis intervention teams, case managers, and follow-up services are available and "ready" when crises arise.

Ultimately, the question is: Why does any community wait for severe abuse or neglect to occur before offering help? Through medical, legal, social service, educational, mental health, and day care systems, early identification of child and family problems is possible. Many families are open to help in overcoming their stresses before a crisis of severe child maltreatment. Through integrated services, which offer a continuum from prevention to institutionalization, more effective outcomes can be achieved. For instance, many "at risk" families need access to basic child development and concrete services.

Advocacy by professionals and clients alike is needed to get primary and secondary preventive education and services to families. Similarly, it is imperative that Child Protective Services improve its public image and gain support. CPS professionals can enhance their image by advocating for parents to receive the skills and supports they need to build strong families and keep children safe.

NOTES

1. H. J. Parad and L. G. Parad, eds., *Crisis Intervention Book 2: The Practitioner's Sourcebook for Brief Therapy* (Milwaukee: Family Service America, 1990), 3–4.

2. R. Borgman, M. Edmunds, and R. A. MacDicken, *Crisis Intervention: A Manual for Child Protective Workers*, U.S. Department of Health, Education and Welfare, National Center on Child Abuse and Neglect (Washington, DC: 1979), 8.

3. Parad and Parad, eds., *Crisis Intervention Book 2*, 5–8.

4. *Ibid*, 8.

5. Borgman, Edmunds, and MacDicken, *Crisis Intervention*, 10–12.

6. S. L. Dixon and R. G. Sands, "Identity and the Experience of Crisis," *Social Casework: The Journal of Contemporary Social Work* 64 (April 1983),224.

7. M. Blugerman, "Contributions of Gestalt Theory to Social Work Treatment," in F. J. Turner, ed., *Social Work Treatment: Interlocking Theoretical Approaches* (New York: The Free Press, 1986), 78.

8. L. Rapoport, "Crisis Intervention as a Mode of Brief Treatment," in R. W. Roberts and R. H. Nee, eds., *Theories of Social Casework* (Chicago: University of Chicago Press, 1970), 297–298.

9. D. A. Puryear, *Helping People in Crisis* (San Francisco: Jossey-Bass, 1979), 51–52.

10. S. L. Dixon, *Working With People in Crisis*, 2nd ed. (Columbia, OH: Merrill, 1987).

11. Puryear, *Helping People in Crisis*, 51–52.

12. *Ibid*, 60.

13. *Ibid*, 87.

14. Dixon, *Working With People in Crisis*, 134.

15. Puryear, *Helping People in Crisis*, 60.

16. D. DePanfilis and M. K. Salus, *Child Protective Services: A Guide for Caseworkers* U.S. Department of Health and Human Services (Washington, DC: 1992), 19.

17. J. L. Jenkins, M. K. Salus, and G. L. Schultze, *Child Protective Services: A Guide for Workers*. U.S. Department of Health, Education and Welfare, National Center on Child Abuse and Neglect (Washington, DC: 1979), 7.

18. C. Towle, *Common Human Needs* (New York: National Association of Social Workers, 1965), 162–163.

19. A. Slaikeu, *Crisis Intervention: A Handbook for Practice and Research* (Boston, MA: Allyn & Bacon, 1990).

20. A. Norman, *Keeping Families Together: A Case for Family Preservation* (New York: Edna McConnell Clark Foundation, 1985), 35–36.

21. N. Golan, *Treatment in Crisis Situations* (New York: Free Press, 1978), 9.

22. Borgman, Edmunds, and MacDicken, *Crisis Intervention*.

23. H. A. Duggan, *Crisis Intervention: Helping Individuals at Risk* (Lexington, MA: Heath, 1984).

24. I. N. Korner, "Crisis Reduction and the Psychological Consultant," in G. A. Specter and W. L. Claiborn, eds., *Crisis Intervention* (New York: Behavioral Publications, 1973), 30–45.

25. Towle, *Common Human Needs*, 163.

26. C. E. Gentry, "Treatment of Child Physical Abuse," in C. M. Mouzakitis and R. Varghese, eds., *Social Work Treatment with Abused and Neglected Children* (Springfield, IL: Charles C. Thomas, 1985), 249,262; and R. J. Gelles, "Abandon Reunification Goal for Abusive Families and Replace with Child Protection," *The Brown University Child and Adolescent Behavior Letter* 8 (June 1992):1,6.

27. M. Kotelchuck, "Child Abuse and Neglect: Prediction and Misclassification," in R. Starr, ed., *Child Abuse Prediction* (Cambridge, MA: Ballinger Publishing, 1982), 67–104.

28. N. Golan, "Crisis Theory," in F. Turner, *Social Work Treatment: Interlocking Theoretical Approaches* (New York: The Free Press, 1986), 319–321.

29. Parad and Parad, eds., *Crisis Intervention Book 2*, 47

30. J. Kinney, D. Haapala, and J. E. Gast, "Assessment of Families in Crisis," in M. Bryce and J. Lloyd, eds., *Treating Families in the Home: An Alternative to Placement* (Springfield, IL: Charles C. Thomas, 1981), 52–53.

31. K. M. Stevenson, K. F. M. Cheung, and P. Leung, "A New Approach to Training Child Protective Services Workers for Ethnically Sensitive Practice," *Child Welfare* 71(July–August 1992):291–305; and D. S. Derezotes and L. R. Snowden, "Cultural Factors in the Intervention of Child Maltreatment Special Issue: Culture and Clinical Social Work." *Child and Adolescent Social Work Journal* 7(April 1990):161–174.

32. C. Horejsi, B. H. R. Craig, and J. Pablo, "Reactions by Native American Parents to Child Protection Agencies: Cultural and Community Factors," *Child Welfare* 71(July–August 1992):329–342.

33. Depanfilis and Salus, *Child Protective Services*.

34. T. Gordon, *Parent Effectiveness Training* (New York: P. H. Wyden, 1970); and S. J. Bavolek, *Shaking, Hitting, Spanking: What To Do Instead* (Park City, UT: Family Development Resources, 1990).

35. Gentry, "Treatment of Child Physical Abuse," 249; Gelles, "Abandon Reunification Goal for Abusive Families and Replace with Child Protection," 1, 6.

36. J. S. Milner, "Applications of the Child Abuse Potential Inventory," *Journal of Clinical Psychology* 45(May 1989):450–454; and J. N. Briere, *Child Abuse Trauma: Theory and Treatment of the Lasting Effects* (Newbury, CA: Sage Publications, 1992), Appendix.

37. J. McCroskey, R. Nishinola, and K. Subramanian, "Assessment in Family Support Programs: Initial Reliability and Validity Testing of the Family Assessment Form," *Child Welfare* 70(January-February 1991):19–32.

38. S. Magura, B. S. Moses, and M. A. Jones, *Assessing Risk and Measuring Change in Families* (Washington, DC: Child Welfare League of America, 1987), 2.

39. A. McEvoy and E. L. Erickson, *Youth and Exploitation: A Process Leading to Running Away, Violence, Substance Abuse and Suicide* (Montreal: Learning Publications, 1990), 14.

40. D. Finkelhor, G. Hotaling, I. A. Lewis, and C. Smith, "Sexual Abuse In a National Survey of Adult Men and Women: Prevalence, Characteristics, and Risk Factors," *Child Abuse and Neglect* 14(1990):19–28.

41. J. M. Gaudin, Jr., N. A. Polansky, and A. C. Kilpatrick, "The Child Well-Being Scales: A Field Trial," *Child Welfare* 71 (July—August 1992):319–328.

42. B. Lewis, "The Wife Abuse Inventory: A Screening Device for the Identification of Abused Women," *Social Work* 35 (January 1990):3234.

43. G. A. Miller, *Substance Abuse Subtle Screening Inventory* (Bloomington, IN: ASASSI Institute, 1985).

44. B. A. Walker and M. Mehr, "Adolescent Suicide—A Family Crisis: A Model for Effective Intervention by Family Therapists," *Adolescence* 18 (Summer 1983):285–292.

45. R. W. Maris, A. L. Berman, J. T. Maltsberger, and R. I. Yufit, *Assessment and Prediction of Suicide* (New York: Guilford Publications, 1992); D. J. Lettieri, "Research Issues in Developing Prediction Scales," in C. Neuringer, ed., *Psychological Assessment of Suicidal Risk* (Springfield, IL: Charles C. Thomas, 1974), 43–73; J. G. Cull and W. S. Gill, "Suicide Probability Scale," in D. J. Kaiser and R. C. Sweetland, eds., *Test Critiques* (Kansas City, MO: Test Corporation of America, Westport Publishers, 1985), 649–655.

46. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington, DC: APA, 1994), 424–429.

47. H. B. Levy, S. H. Sheldon, and J. R. Conte, "Special Intervention Programs for Child Victims of Violence," in M. Lystad, ed., *Violence in the Home: Interdisciplinary Perspectives* (New York: Brunner-Mazel, Inc., 1986), 195–196.

48. A. C. Salter, *Treating Child Sex Offenders and Victims: A Practical Guide* (Newbury Park, CA: Sage Publications, 1988); J. J. Mead and D. L. Westgate, *Sex Offender Case Management* (Chino, CA: R. C. Law and Company, 1992), C–4, C–5.

49. E. H. Plumer, *When You Place A Child* (Springfield, IL: Charles C. Thomas, 1992).

50. S. Jayaratne, "A Study of Clinical Eclecticism," Social Services Review 52(December 1978):621–631, and J. C. Norcross, ed., *Handbook of Eclectic Psychotherapy* (New York: Brunner-Mazel, 1986).

51. Parad and Parad, eds., *Crisis Intervention Book* 2, 22.

52. A. Ellis and R. Grieger, eds., *Handbook of Rational-Emotive Therapy* (New York: Springer, 1977).

53. J. Kinney, D. Haapala, and C. Booth, *Keeping Families Together: The Homebuilders Model* (Hawthorne, NY: Aldine de Gruyter, 1991).

54. H. H. Perlman, *Social Casework: A Problem-Solving Process* (Chicago: University of Chicago Press, 1957), 25–26.

55. J. L. Walter and J. E. Peller, *Becoming Solution-Focused in Brief Therapy* (New York: Brunner-Mazel Publishers, 1992), 28–29, 247–249.

56. D. V. Fandetti, "Issues in the Organization of Services for Child Abuse and Neglect," in C. M. Mouzakitis and R. Varghese, *Social Work Treatment with Abused and Neglected Children* (Springfield, IL: Charles C. Thomas, 1985), 383.

57. C. Garrison and J. Weber, "Family Crisis Intervention Using Multiple Impact Therapy," *Social Casework* 62 (December 1981):585–593.

58. J. H. Brown, W. A. Finch, Jr., H. Northern, S. A. Taylor, and M. Weil, *Child, Family, Neighborhood: A Master Plan for Social Service Delivery* (New York: Child Welfare League of America, Inc., 1982).

59. American Association for Protecting Children, *AAPC's Framework for Advocacy* (Denver, CO: American Humane Association, 1989).

60. Kinney, Haapala, and Gast, "Assessment of Families in Crisis," 54–55; C. E. Gentry and V. B. Eaddy, "Treatment of Children in Spouse Abusive Families," *Victimology: An International Journal* 5(2–4 1980):240–250; and J. S. Milner and C. Chilamkurti, "Physical Child Abuse Perpetrator Characteristics: A Review of the Literature," *Journal of Interpersonal Violence* 6(September 1991):360–361.

61. Milner and Chilamkurti, "Physical Child Abuse Perpetrator Characteristics: A Review of the Literature," *Journal of Interpersonal Violence* 6 (September 1991): 360–361.

62. Ellis and Grieger, eds., *Handbook of Rational-Emotive Therapy*.

63. J. Wolpe, *The Practice of Behavior Therapy*, 3rd ed. (New York: Pergamon Press, 1982); and J. Vincent, ed., *Advances in Family Intervention, Assessment and Theory* (Greenwich, CT: JAI Press, 1980).

64. R. J. Thomlison, "Behavior Therapy in Social Work Practice," in F. J. Turner, ed., *Social Work Treatment: Interlocking Theoretical Approaches*, 3rd ed. (New York: The Free Press, 1986), 146–148.

65. W. J. Reid, *The Task-Centered System*. (New York: Columbia University Press) 1978; and J. Larsen and C. Mitchell, "Task-Centered Strength-Oriented Group Work With Delinquents." *Social Casework* 61(March 1980):154–163.

66. M. Bowen, *Family Therapy in Clinical Practice* (New York: Jason Aronson, 1978); and S. Minuchin, *Families and Family Therapy*, (Cambridge, MA: Harvard University Press, 1974).

67. Thomlison, "Behavior Therapy in Social Work Practice," 131–154.

68. H. D. Werner, "Cognitive Theory," in F. J. Turner, ed., *Social Work Treatment: Interlocking Theoretical Approaches*, 3rd ed. (New York: The Free Press, 1986), 126.

69. M. Lystad, ed., *Violence in the Home: Interdisciplinary Perspectives* (New York: Brunner-Mazd, Inc., 1986), 104.

70. K. Hallett, *A Guide for Single Parents: Transactional Analysis for People in Crisis* (Millbrae, CA: Celestial Arts, 1974).

71. M. R. Rodway, "Systems Theory," in F. J. Turner, ed., *Social Work Treatment: Interlocking Theoretical Approaches*, 3rd ed. (New York: The Free Press, 1986), 515–516; and M. Bowen, *Family Therapy in Clinical Practice* (New York, Jason Aronson, 1978).

72. D. F. Krill, "Existential Social Work," in F. J. Turner, ed., *Social Work Treatment: Interlocking Theoretical Approaches*, 3rd ed. (New York: The Free Press, 1986), 181–218.

73. J. Fagan and I. L. Shepherd, eds., *Gestalt Therapy Now: Theory, Techniques, Applications* (Palo Alto, CA: Science and Behavior Books, 1970), 91.

74. C. Rogers, *A Way of Being* (Boston: Houghton Mifflin, 1980).

75. Walter and Peller, *Becoming Solution-Focused in Brief Therapy*.

76. M. Salus and J. Alderson, *Family Advocacy Officers: Clinical Seminar* I (Washington, DC: Creative Associates, Inc., 1984).

77. Georgia Social Services Certification Training: Intervention "Interviewing Techniques with Resistant Clients," (Atlanta, GA: Child Welfare Institute, 1990).

78. R. J. Burant, ed., Families in Society: *The Journal of Contemporary Human Services. A Special Issue: Multicultural Practice* 73(June 1992).

79. J. D. Lovern, *Pathways to Reality: Erickson-Inspired Treatment Approaches to Chemical Dependency* (New York: Brunner-Mazel, 1991).

80. R. Counts and A. Sacks, "The Need for Crisis Intervention During Marital Separation," *Social Work* 30(March-April 1985):146–149.

81. W. N. Friedrich, *Psychotherapy of Sexually Abused Children and Their Families* (New York: W. W. Norton, 1990), 186.

82. J. S. Wallerstein, "The Overburdened Child: Some Long-term Consequences of Divorce." *Social Work* 30 (March–April 1985):116–122.

83. D. Whitsett and H. Land, "Role Strain, Coping, and Marital Satisfaction of Stepparents." *Families in Society: A Journal of Contemporary Human Services* 73(February 1992):89–91.

84. A. M. Fulton, K. R. Murphy, and S. L. Anderson, "Increasing Adolescent Mothers' Knowledge of Child Development: An Intervention Program," *Adolescence* 26(Spring 1991):73-81.

85. S-Y. Kang, P. H. Kleinman, G. E. Woody, and R. B. Millman, et. al., "Outcomes for Cocaine Abusers After Once-A-Week Psychosocial Therapy," *American Journal of Psychiatry* 148(May 1991):630–635.

86. T. Gorski, "Relapse Prevention Planning." *Addiction and Recovery* 10(June 1990):41–44.

87. L. Thompson, "Working With Alcoholic Families in A Child Welfare Agency: The Problem of Under diagnosis." *Child Welfare* 69(September–October 1990):463.

88. P.L. Whitney and L. Davis, "Child Abuse and Woman Abuse: Understanding the Connection and Designing Safe Interventions," *Common Ground* 10(November1994):5.

89. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed.

90. N. A. Polansky, M. Chalmer, E. Buttenwieser, and D. P. Williams, *Damaged Parents: An Anatomy of Child Neglect* (Chicago: University of Chicago Press, 1981), 43; J. M. Gaudin, Jr., *Child Neglect: A Guide for Intervention* (Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, 1993), 56.

91. V. Pillari, *Scapegoating in Families: Intergenerational Patterns of Physical and Emotional Abuse* (New York: Brunner-Mazel, 1991).

92. M. H. Stone, *The Fate of Borderline Patients* (New York: Guilford Press, 1990); and L. Grinspoon, ed., "Dissociation and Dissociative Disorders: Part I." *The Harvard Mental Health Letter* 8(March 1992):1–4.

93. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., 629–673, 484–487.

94. L. Grinspoon, ed., "Dual Diagnosis: Part II." *The Harvard Mental Health Letter* 8(September 1991):1.

95. P. J. Pecora, M. W. Fraser, D. Haapala, and J. A. Bartlome, "Defining Family Preservation Services: Three Intensive Home-Based Treatment Programs," *Research Report Number 1 from the Family-Based Intensive Treatment Research Project* (Salt Lake City: Social Research Institute, University of Utah School of Social Work, 1987); M. A. Jones, "Measuring Outcomes," in K. Wells and D. E. Biegel, eds., *Family Preservation Services: Research and Evaluation* (Newbury Park, CA: Sage Publications, 1991); Barthel, *For Children's Sake: The Promise of Family Preservation*, 42; and K. E. Nelson and M. J. Landsman, *Alternative Models of Family Preservation: Family-Based Services in Context* (Springfield, IL: Charles C. Thomas, 1992).

96. DePanfilis and Salus, *Child Protective Services*, 80.

97. L. M. Markowitz, "Making House Calls," *Networker* 16(July–August 1992):32.

98. Morton and Salus, *Supervising Child Protective Services Caseworkers*, 1994.

99. V. G. Hodges and B. J. Blythe, "Improving Service Delivery to High-Risk Families: Home-Based Practice," *Families in Society* 73(May 1992):263–264.

100. J. Chambers and S. Ederstein, *Homebuilders Follow-up Training Information*, presented at the State of Tennessee Department of Human Services, by the Behavioral Sciences Institute, Federal Way, WA in Nashville, TN, January 22–23, 1990.

101. J. Kinney, D. Haapala, and C. Booth, *Keeping Families Together: The Homebuilders Model*, 1991; E. M. Tracy, D. A. Haapala, J. Kinney, and P. J. Pecora, eds., *Intensive Family Preservation Services: An Instructional Sourcebook* (Cleveland: Casewestern Reserve University, 1991); and J. K. Whittaker, J. Kinney, E. M. Tracy, and C. Booth, eds., *Reaching High-Risk Families: Intensive Family Preservation in Human Services* (New York: Aldine de Gruyter, 1990).

102. L. Woods, "Home Based Family Therapy." *Social Work* 33(May–June 1988):211–214.

103. A. Norman, *Keeping Families Together: A Case for Family Preservation* (New York: Edna McConnell Clark Foundation, 1985), 35–36.

104. K. Nelson, A. Emlen, M. J. Landsman, and J. Hutchinson, *Factors Contributing to Success and Failure in Family-Based Child Welfare Services* (Iowa City, IA: National Center on Family-Based Services, The University of Iowa School of Social Work, 1988).

105. J. C. Lloyd and M. E. Bryce, *Placement Prevention and Family Reunification: A Handbook for the Family-Centered Service Practitioner*, revised (Iowa City, IA: National Resource Center on Family-Based Services, The University of Iowa School of Social Work, 1984); Nelson, Emlen, Landsman, and Hutchinson, *Factors Contributing to Success and Failure in Family-Based Child Welfare Services*.

106. W. J. Reid and L. Epstein, eds., *Task-Centered Practice* (New York: Columbia University Press, 1977).

107. S. Minuchin, B. Montalvo, B. G. Guerney, Jr., B. L. Rosman, and F. Schumer, *Families of the Slums: An Exploration of Their Structure and Treatment* (New York: Basic Books, 1967).

108. S. Minuchin and H. C. Fishman, *Family Therapy Techniques* (Cambridge, MA: Harvard University Press, 1981).

109. R. Bandler, J. Grinder, and V. Satir, *Changing with Families: A Book About Further Education for Being Human* (Palo Alto, CA: Science and Behavior Books, 1976).

110. B. Seabury, "Communication Problems in Social Work Practice," *Social Work* 25(January 1980):40-44.

111. R. L. McNeely and M. K. Badan, "Interracial Communication in School Social Work," *Social Work* 29 (January–February 1984):22–26.

112. G. R. Weeks and L. L'Abate, *Paradoxical Psychotherapy: Theory and Practice with Individuals, Couples, and Families* (New York: Brunner-Mazel, 1982); P. Papp, *The Process of Change* (New York: Guilford Press, 1983); P. Watzlawick, J. Beavin, and D. Jackson, *Pragmatics of Human Communication: A Study of International Patterns, Pathologies, and Paradoxes* (New York: Norton, 1967); and M. Selvini-Palazzoli, L. Boscolo, G. Cecchin, and G. Prata, Paradox and Counter Paradox (New York: Aronson, 1978).

113. J. H. Weakland, R. Fisch, P. Watzlawick, and A. M. Bodin, "Brief Therapy: Focused Problem Resolution," *Family Process* 13(June 1974):156.

114. S. J. Bavolek, *The Nurturing Program* (Eau Claire, WI: Family Development Resource, Inc., 1991); and Gentry, "Treatment of Child Physical Abuse."

115. American Association for Protecting Children, *AAPC's Framework for Advocacy*; and R. Sunley, *Advocating Today: A Human Service Practitioner's Handbook* (New York: Family Service of America, 1983).

116. T. N. Tavantzis, M. Tavantzis, L. G. Brown, and M. Rohobaugh, "Home-Based Structural Family Therapy for Delinquents at Risk of Placement," in M. P. Mirkin and S. Koman, eds., *Handbook of Adolescent and Family Therapy* (New York: Gardner Press, 1986).

117. S. Minuchin, *Families and Family Therapy* (Cambridge, MA: Harvard University Press, 1974).

118. C. Madanes, *Strategic Family Therapy* (San Francisco: Jossey-Bass, 1981).

119. S. L. Rhodes, "Family Treatment," in F. J. Turner, ed., *Social Work Treatment: Interlocking Theoretical Approaches* (New York: The Free Press, 1986), 449.

120. L. Bellak and H. Siegel, *Handbook of Intensive Brief and Emergency Psychotherapy* (Larchmont, NY: C.P.S., Inc., 1983), 3.

121. L. Epstein, *Helping People: The Task-Centered Approach* (St. Louis: The C. V. Mosby, Co., 1980); A. E. Fortune, *Task-Centered Practice with Families and Groups* (New York: Springer, 1985); J. Larson and C. Mitchell, "Task-Centered Strength-Oriented Group Work With Delinquents," *Social Casework* 61(March 1980); W. J. Reid, *The Task-Centered System* (New York: Columbia University Press, 1978); and Reid and Epstein, eds., *Task-Centered Practice*.

122. Walter and Peller, *Becoming Solution-Focused in Brief Therapy*, 28.

123. J. C. Nelsen, "Communication Theory and Social Work Treatment," in F. J. Turner, ed., *Social Work Treatment: Interlocking Theoretical Approaches* (New York: The Free Press, 1986), 219–244.

124. C. Nadelson and M. Sauzier, "Intervention Programs for Individual Victims and Their Families," in M. Lystad, ed., *Violence in the Home: Interdisciplinary Perspectives* (New York: Brunner-Mazel, Inc., 1986), 161–163.

125. R. E. Liles and A. O'Brien, "Crisis Intervention in Intrafamilial Child Sexual Abuse," in H. J. Parad and L. G. Parad, eds., *Crisis Intervention Book 2*, 119–138.

GLOSSARY OF TERMS

Borderline Personality Disorder—Characterized by instability of self-image, mood, and interpersonal relationships by early adulthood. Impulsiveness, poor anger control, suicidal or self-mutilating behaviors, intense fear of abandonment, feelings of emptiness, and affective instability are present fairly frequently and in response to real or imagined stress.

Case Plan—The professional document which specifies the goals and strategies to be used to change the conditions and behaviors contributing to child abuse and neglect.

Case Planning—The stage of the child protection intervention process when the CPS caseworker and other service providers develop a case plan with the family members.

Co-morbidity—The co-existence of syndromes or diagnosable disorders such as mental illness and alcoholism or mental illness and mental retardation.

Crisis—A situation or circumstance, usually of recent origin, which breaks down the individual's or the family's usual pattern of functioning and cannot be resolved with usual coping behaviors. Generally, clients can wait 24 to 72 hours for a response, and the acute crisis state will last no longer than 4 to 6 weeks.

Dissociative Identity Disorder—Formerly multiple personality disorder. Two or more personality states that recurrently take control of behavior, and there is inability to recall important personal information.

Dual Diagnosis—The co-existence of two conditions. Examples are mental illness and substance abuse, or mental retardation and mental illness.

Evaluation of Family Progress—The stage of the child protection intervention process (after the case plan has been implemented) when the CPS caseworker and other service providers determine changes in family behaviors, the reduction of risk of child maltreatment, and the need for continued services. Frequently, community service providers coordinate their evaluation of case progress through periodic team meetings.

Family Assessment—The stage of the child protection process when the CPS caseworker, other service providers, and the family reach a mutual understanding about the most critical service and treatment needs and the family strengths on which to build.

Family-Based, Home-Based, or In-Home Services—Early interventions that are aimed at keeping children in their homes, keeping family members safe, and strengthening the family unit.

Family Preservation Services—Coordinated and time-limited crisis intervention services, aimed at preventing removal of a child to out-of-home care, while also assuring the child's and family's safety.

Flashback—The emotional reexperiencing of a traumatic event.

Multidisciplinary Team—A group established among agencies and professionals within the child protection system to discuss cases of child abuse and neglect and make decisions during various stages of the case.

Multiple Personality Disorder—Two or more distinct personalities exist within a person.

Nonoffending Parent (NOP)—Particularly in incest cases, this term is used to designate the parent who is not an active abuser of the child.

Out-of-Home Care—Respite care, foster care, or residential care provided by persons, organizations, and institutions to children living away from their families, usually under the jurisdiction of Juvenile/Family Court.

Post-Traumatic Stress Disorder—A diagnosis based on symptoms of fear, terror, helplessness, avoidance of stimuli associated with past trauma, emotional numbing, sleep problems, irritability, hypervigilance, depression, anxiety, and poor concentration.

Primary Prevention—Activities or education for the general populous in an attempt to prevent child abuse and neglect.

Risk—The likelihood that a child will be maltreated in the future.

Risk Assessment—An assessment and measurement of the likelihood that a child will be maltreated in the future, usually through the use of checklists, matrixes, scales, and/or other methods of measurement.

Risk Factors—Behaviors and conditions present in the child, parent, family, and/or community which suggest that child maltreatment may occur in the future.

Secondary Prevention—Early intervention activities targeted to prevent breakdowns and dysfunction among families identified as "at-risk" for child abuse and neglect.

Treatment—The stage of the child protection intervention process when CPS, other crisis intervention workers, and/or other service providers work toward the reduction of child maltreatment risk.

Wrap-around Services—Family preservation services, geared to meet the total needs of the family through the use of community resources, concrete services, and counseling.

SELECTED BIBLIOGRAPHY

OVERVIEWS

Brown, S. L. *Counseling Victims of Violence*. Alexandria, VA: American Association for Counseling and Development, 1991.

Gomes-Schwartz, B.; Horowitz, J. M.; and Cardarelli, A. P. *Child Sexual Abuse: The Initial Effects*. Newbury Park, CA: Sage Publications, 1990.

Grigsby, R. K. "Theories That Guide Intensive Family Preservation Services: A Second Look." *In Advancing Family Preservation Practice*, edited by E. S. Morton and R. K. Grigsby. Newbury Park, CA: Sage Publications, 1993.

Quina, K., and Carlson, N. L. *Rape, Incest, and Sexual Harassment, A Guide for Helping Survivors*. New York: Praeger Publishers, 1989.

Stith, S. M.; Williams, M. B.; and Rosen, K., eds. *Violence Hits Home: Comprehensive Treatment Approaches to Domestic Violence*. New York: Springer Publishing Co., 1990.

Williams, M. B. "School Social Work with Victims of Trauma." *Iowa Journal of School Social Work* 5(December 1990):11–19.

THERAPY AND COUNSELING FOR CHILDREN, PARENTS, AND FAMILIES

Jinich, S. *Supportive Response Training for Parents of Sexually Abused Children*. Washington, DC: National Center on Child Abuse and Neglect, 1993.

Johnson, K. *Trauma in the Lives of Children. Crisis and Stress Management Techniques for Teachers, Counselors, and Student Service Professionals*. Alameda, CA: Hunter House, 1989.

Kochis, K. "Parent Education and Child Protection: An Intervention Strategy." *Common Ground* 11(February 1994): 20.

McCown, W. G., and Johnson, J. *Therapy with Treatment Resistant Families: A Consultation-Crisis Intervention Model*. Binghamton, NY: Haworth Press, 1993.

McWilliam, P. J., and Bailey, D. B., eds. *Working Together with Children and Families: Case Studies in Early Intervention*. Baltimore: Paul H. Brookes Publishing Co., 1993.

Van Ornum, W., and Mordock, J. B. *Crisis Counseling with Children and Adolescents: A Guide for Nonprofessional Counselors*. New York: Continuum Publishing Co., 1991.

Webb, B. B., ed. *Play Therapy with Children in Crisis: A Casebook for Practitioners*. New York: Guilford Press, 1991.

CRISIS INTERVENTION PROGRAMS

ARCH National Resource Center for Crisis Nurseries and Respite Care Services. *Starting a Crisis Nursery Program*. Chapel Hill, NC: ARCH National Resource Center for Crisis Nurseries and Respite Care Services, 1993.

Nelson, K. E.; Landsman, M. J.; and Deutelbaum, W. "Three Models of Family-Centered Placement Prevention Services." *Child Welfare* 69(January–February 1990):3–21.

Pitcher, G. D., and Poland, S. *Crisis Intervention in the Schools*. New York: Guilford Press, 1992.

Vaughan, M. L., and Loedman, W. E. *Crisis Nurseries: A Promising Approach to Preventing Child Abuse and Neglect in the United States*. Columbus, OH: North Side Child Development Center-Turning Point, 1990.

OTHER RESOURCES

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(704) 529–1080

American Academy of Pediatrics
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P.O. Box 927
Elk Grove Village, IL 60009–0927
(800) 433–9016

American Bar Association
Center on Children and the Law
1800 M Street, NW
Suite 200
Washington, DC 20036
(202) 331–2250

American Humane Association
American Association for Protecting Children
63 Inverness Drive East
Englewood, CO 80122–5117
(303) 792–9900
(800) 227–5242

American Medical Association
Health and Human Behavior Department
535 North Dearborn
Chicago, IL 60610
(312) 645–5065

American Professional Society on the Abuse of Children (APSAC)
407 South Dearborn
Suite 1300
Chicago, IL 60605
(312) 554–0166

American Psychiatric Association
1400 K Street, N.W.
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American Psychological Association
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American Public Welfare Association
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University of Colorado Health Services Center
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1205 Oneida Street
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Child Welfare League of America (CWLA)
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Childhelp USA
6463 Independence Avenue
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(800)422–4453

Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013
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Military Family Resource Center (MFRC)
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